Maternal and Child Health Services
Title V Block Grant

State Narrative for Texas

Application for 2011
Annual Report for 2009

Document Generation Date: Saturday, September 18, 2010

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

As per the Title V Block Grant Guidance expiring March 31, 2012, the appropriate assurances and certifications are being maintained Department of State Health Services central office and are available upon request. Please contact Sam Cooper at 512-458-7111, extension 2184, and/or Kim Roberts at extension 3207 if you have questions or need to view the assurances and certifications.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

A key goal in planning all activities related to Texas' FY11 Five-Year Needs Assessment and Block Grant Application was a commitment to include all potential external stakeholders in all stages of the process. To ensure input for the Five-Year Needs Assessment was directly from and inclusive of as many public partners, providers, consumers, and other stakeholders interested and impacted by maternal and child health (MCH) issues as possible, the Department of State Health Services (DSHS) contracted with an outside agency to assist with implementation of an external stakeholder input process. The contractor was tasked with obtaining recommendations for establishing the state priorities for the next five years. The process incorporated a wide variety of methods and venues: community and state-level meetings, group presentations, web-based surveys, facilitated exercises, email communication, newsletter articles, and website information.

Consumers, providers, advocates, stakeholders, and local health administrators were actively recruited to participate in 50 Community Listening Sessions in 19 different locations across the state. Subsequently, a web-based survey was administered to all 439 Community Listening Session participants and later a second web-based survey was administered to participants who indicated an ongoing interest in participating in the stakeholder input process and to state-level partners and advocacy groups. Many of these interested participants also attended a day and a half Stakeholder Summit to determine final recommendations for state-level MCH priorities.

After the ten MCH priority needs were drafted, a Public Forum was held in each of the eight DSHS regional headquarters to share the multi-stage stakeholder input process, how the proposed priorities were developed, and how they will be used in the block grant application. The forums were open to anyone and all participants were given an opportunity to express their opinions. A number of avenues were used to notify the public about the forums. The recruitment for the Public Forums was done using the extensive Title V distribution lists generated at the earlier stages of Needs Assessment stakeholder input gathering process. Flyers and posters

were mailed out to the various locations and distribution lists. E-mail notices and reminders were also sent out to the distribution lists. A toll-free line handled any questions from possible public forum attendees. A website specific to the Five-Year Needs Assessment process also provided information on the public forums.

Also in relation to the Five-Year Needs Assessment, the Children with Special Health Care Needs Service Program (CSHCN SP) obtained input focused on children and youth with special health care needs (CYSHCN) from independent surveys of parents, providers, and Community Resource Coordination Group (CRCG) participants; meetings with key statewide advisory councils/groups and collaborative initiatives; and focus group meetings with families. CSHCN SP staff ensured accessibility to these methods for families by using a written format that could easily be reproduced and distributed without needing to have computer access; by translating the documents into Spanish; and by insuring that the documents were written in plain language at a sixth-grade literacy level. For providers and CRCG participants, surveys were made available in an online format.

A draft of the Five-Year Needs Assessment was posted on the MCH section of the DSHS website in April 2010 prior to finalizing the document. An e-mail announcing the posting and inviting comment and suggestions was sent using the aforementioned stakeholder distribution list. A web-based response tool (Needs Assessment Public Comment Survey) was provided to collect public comment.

In addition to public input efforts more specific to the Five-Year Needs Assessment, DSHS employs a number of methods to obtain input and feedback from the public throughout the year. The bi-annual Community Health Services Contractor Roundtables are a mechanism to obtain valuable information from DSHS contracted direct service providers since they represent a diverse cross-section of Texas communities and provide firsthand experience in service delivery. Moreover, discussion time is allotted during Title V quarterly contractor and regional staff conference calls to share information about best practices and challenges in serving MCH populations.

In the absence of a formal stakeholder advisory organization supported through Title V, DSHS staff regularly convenes and attends formal and informal advisory workgroups, steering committees, councils, task forces, and other groups to address emerging issues and work on collaborative initiatives related to MCH populations throughout the year.

The MCH section of the DSHS website (http://www.dshs.state.tx.us/mch/default.shtm) contains regularly updated information about Title V and related programs as well as resource materials for public use. This site is used to post past Title V Block Grant Applications as well as the current and past Five-Year Needs Assessments. The draft FY11 Activity Plans for each of the national and state Title V performance measures were posted for public comment the end of June 2010 with notification of the posting sent via email to the stakeholder distribution list and the FY11 Block Grant Application will be posted after submission using the same notification process.

The stakeholder distribution list will be the basis for ongoing and future communication with partners, families, providers, consumers, and other stakeholders interested and impacted by MCH issues.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

In conducting the FY11Title V Five-Year Needs Assessment, DSHS made considerable efforts to ensure that stakeholder input was direct and inclusive of as many partners, providers, consumers, and other stakeholders interested and impacted by MCH issues as possible. The process incorporated a wide variety of methods and venues to gather input from and establish ongoing communication with stakeholders: community meetings, state-level meetings, group presentations, web-based surveys, facilitated exercises, email communication, newsletter articles, and website information.

The extensive stakeholder input process resulted in a ranked list of 24 recommended need statements. The Needs Assessment Planning Group reviewed the statements in the context of the quantitative data that was gathered and then consolidated them based on similarities of populations, services, or functions. Based on the themes that emerged, the group formulated 10 priority needs for the State of Texas. All three Title V MCH populations are included in the new priorities and aspects of prevention, primary care, and services for CYSHCN have been woven throughout the set. The priorities focus on the areas of:

- Access to care across the life course,
- Mental health and substance abuse,
- CYSHCN transition,
- Dental care,
- Healthy child and adolescent development,
- Essential enabling services,
- CYSHCN community-based systems of care,
- Population-based health promotion and disease prevention,
- Health care provider workforce development and retention, and
- Evidence-based interventions.

Following presentations of the proposed priorities to DSHS Executive Leadership and Health Service Region Leadership, the Title V Director shared the proposed priorities through public forums held in each of the eight regional headquarter cities. Feedback received indicated that the proposed priorities were considered valid and within the potential scope of DSHS and Title V-funded activities.

Due in part to the changes in methodology for conducting the FY11 Five-Year Needs Assessment, the priority needs have changed from those identified in FY06. While there appear to be differences in the two lists, the majority of priorities identified in FY06 are embodied under the new priority statements, even if they are not spelled out specifically. The new priorities are meant to serve as a framework that can be used as a guide for the future. This flexibility will allow DSHS to adapt Title V activities to meet new requirements resulting from actions such as possible state budget reductions and/or federal health care reform. The priority to increase access to dental care is the only priority from FY06 to remain in the current list, primarily because of the consistent stakeholder feedback related to unmet needs in this area.

Specifically for CYSHCN in Texas, the most important needs continue to be family participation, increased community-based services and reduction of congregate care; advancement of medical home services; improved transition services and service system coordination; and targeting

services based on data analysis of social, demographic, and condition-specific determinants of health and quality of life outcomes of CYSHCN.

With the focus on stakeholder input as a guide, DSHS chose to evaluate capacity according to the proposed priorities that resulted from the Needs Assessment process. Using the members of the DSHS Title V Needs Assessment Steering Committee as contact points for each division, an assessment tool was provided to gauge capacity in areas related to funding, staffing, policies, information systems, and partnerships. In addition, divisions were asked to assess the alignment of these proposed priorities with existing division goals.

DSHS capacity to address the priorities and needs of the MCH population in Texas includes challenges in available and sustainable funding, information technology, and untapped public/private/academic partnerships. These challenges will be explored further, and specific activities within the Title V national and state performance measures were developed to strengthen those areas within the context of the department's responsibilities as the public health agency, the potential changes in health care systems, and the state budget over the next five-year period.

III. State Overview

A. Overview

Successful implementation of Title V activities in Texas depends on an ability to predict, understand, and develop strategies around factors that impact the health and well-being of women, children, and families in the context of their communities. The following description of geographic, demographic, economic, and social trends provides an overview of select characteristics for Texas.

LAND AREA

Texas' land area is approximately 262,000 square miles, accounting for 7.4% of the total U.S. land area. The area is equal to the land area of all six New England states, Ohio, New York, Pennsylvania, and North Carolina combined. The longest straight-line distance in a general north-south direction is 801 miles from the northwest corner of the Panhandle to the extreme southern tip of Texas on the Rio Grande below Brownsville. With the large north-south expanse of Texas, Dalhart, in the northwestern corner of the state, is closer to the state capitals of Kansas (~430 miles), Colorado (~310 miles), New Mexico (~200 miles), Oklahoma (~275 miles), and Wyoming (~390 miles) than it is to Austin (~470 miles), its own state capital. The greatest east-west distance is 773 miles from the extreme eastward bend in the Sabine River in Newton County to the extreme western bulge of the Rio Grande just above El Paso. This east-west expanse is so large that El Paso, in the western corner of the state, is closer to San Diego, California (~630 miles) than to Beaumont (~740 miles), near the Louisiana state line; Beaumont, in turn, is closer to Jacksonville, Florida (~680 miles) than it is to El Paso. Finally, Texarkana, in the northeastern corner of the state, is about the same distance from Chicago, Illinois as it is to El Paso (~750 miles). Given the size of Texas, the distance some individuals must travel to receive services is a significant barrier to accessing and receiving those services.

METROPOLITAN, MICROPOLITAN, RURAL, AND BORDER COUNTIES

Texas has a mixture of urban, rural, and border populations. According to the Office of the State Demographer, the majority of Texans live in urban areas (91.9%). Of the 254 counties in Texas, 156 are rural, accounting for approximately 8.1% of the 2008 Texas. In addition to urban and rural areas, Texas is one of four states that shares a geographic border with Mexico. As defined in the La Paz Agreement of 1983, the border region includes the area within 100 kilometers (or 62 miles) of the Rio Grande River. By this definition, the Texas border region includes 32 of Texas' 254 counties and 10.2% of the Texas population. Of these 32 counties, four are urban.

The length of the Texas-Mexico border accounts for 45.1% of the 1,969 mile U.S. - Mexico border. The majority of the population along the entire U.S. - Mexico border resides in 14 pairs of U.S. - Mexico sister cities. Seven of the 14 pairs are located in Texas. The sister cities along the U.S. - Mexico border are linked economically, culturally, and environmentally. According to the U.S. Department of Transportation, in 2007, there were 26,274,077 trains, buses, trucks, and personal vehicles and 62,054,088 people who entered the U.S. at Texas border checkpoints.

Each of these geographic designations presents a unique service delivery challenge. In urban areas, services must meet the demands of a large, concentrated population. Service delivery challenges of rural area residents include the unavailability and inaccessibility of affordable health care, lack of transportation, limited fiscal resources, little or no economic development, and the absence of trained healthcare professionals. While service needs may be similar between those residing in urban and rural areas, cultural norms and values may be different in urban and rural communities requiring outreach strategies uniquely tailored to each community. In the border region, challenges include limited infrastructure, a developed bi-national culture unique to the region, and cross- border utilization of services.

POPULATION

According to the U.S. Census Bureau, the estimated 2008 Texas population was 24.3 million people, which accounted for 8.0% of the total U.S. population. Texas' population is equivalent to the individual populations of 11 other states combined. Texas is also home to six of the 21 largest cities in the U.S. (Houston -- 4th, San Antonio -- 7th, Dallas -- 9th, Austin -- 16th, Fort Worth -- 19th, and El Paso -- 21st).

Between 1990 and 2008, the Texas population increased 42.5% compared to the overall growth in the U.S. of 22.3%. Between 2000 and 2008, the Texas population increased 16.6% compared to the overall growth in the U.S. of 8.2%. Texas was the seventh fastest growing state between 1990 and 2008 and the sixth fastest growing state between 2000 and 2008. Population growth varies throughout Texas. Areas surrounding three of the state's largest urban areas, Dallas/Fort Worth, Houston, and San Antonio/Austin experienced some of the most significant growth between 2000 and 2008. According to the Texas State Data Center, Texas' population will exceed 25 million people during the year 2010, and by 2040 will reach a population in excess of 43 million people. Between 2000 and 2020, the Texas population is expected to increase by 45.1%.

The Texas State Data Center estimated that 10.2% (2,472,030) of the 24,326,974 Texas residents in 2008 resided along the Texas Border. Of these 2.5 million border residents, 58.0% of them were less than 35 years old, compared to the non-border population, where only 51.8% of them were less than 35. Similarly, urban counties have a younger population. Of the 22,360,411 Texas residents residing in an urban county, 53.0% were less than 35 years old, compared to 45.6% in rural counties.

POPULATION ALONG THE TEXAS-MEXICO BORDER

Between 1950 and 2000, the U.S. - Mexico border population increased by approximately 10 million people; between 1990 and 2008, the population in the Texas -- Mexico border region increased by 44.9%. Populations along the border have increased significantly over the past 20 years, due in part to the maquiladora program begun in 1965. This program provided economic incentives to foreign (mostly U.S.-owned) assembly factories located in the border region. With about 1,700 factories operating in Mexico in 1990, the rate of industrial development increased further after the North American Free Trade Agreement. By 2001, the 1,700 factories had more than doubled to nearly 3,800 maquiladora factories, 2,700 of which were in Mexican-border states.

The demand for affordable housing in areas along the Texas-Mexico border has contributed to the development of colonias in this region. According to the Texas Secretary of State, colonias are "residential areas along the Texas-Mexico border that may lack some of the most basic living necessities, such as potable water and sewer systems, electricity, paved roads, and safe and sanitary housing." There are approximately 400,000 Texans residing in more than 2,000 existing colonias.

In the coming years, population growth is expected to continue along the Texas-Mexico border. Estimates indicate that between 2008 and 2020, the population in the border region will increase 30.9%. Growth along this region has led to a number of quality of life improvements for residents such as paved streets and access to education. However, this population growth is also a potential burden on the health care system on both sides of the border, which could result in limited health care access and contribute to significant cross-border utilization of services.

AGE AND SEX BREAKDOWN IN TEXAS: YOUNG ADULTS AND WOMEN OF CHILDBEARING AGE

The population of Texas is relatively young compared to the rest of the nation. The 2008

estimated Texas median age was 33.2 years, 3.6 years younger than the estimated median age of 36.8 years for the entire U.S. This makes Texas 2nd only to Utah (median age 28.7) as the nation's "youngest" state (including Washington, DC).

The Texas State Data Center estimated the 2008 total female population of Texas at 12,137,007 (49.9% of the overall population). Women of childbearing age (15 to 44 years) comprised 43.5% of the total female population. Between 2000 and 2020 in Texas, the population of women 15 to 44 years of age is expected to increase by 32.5%, an increase of 1.4 million women.

RACIAL/ETHNIC COMPOSITION OF TEXAS

In 2008, the estimated Texas population included approximately 11.3 million Non-Hispanic Whites (46.6%), 9.1 million Hispanics (37.5%), and 2.8 million Blacks (11.6%). In 2000, 59.5% of Texans five years old and younger and 56.5% of Texans younger than 20 years of age were non-White. These figures foreshadow the emergence of the changing race/ethnicity composition of Texas. By 2015, the number of Hispanics in Texas is estimated to exceed the number of Whites. By 2020, the number of Whites in Texas is projected to increase by 3.5%, while the number of Hispanics is projected to increase by 108.7% during the same time period. In 2000, Whites accounted for 53.1% of the total population in Texas. It is estimated that they will account for 37.9% by 2020, a 28.6% decrease. Conversely, in 2000, Hispanics accounted for 32.0% of the total population in Texas. It is estimated that they will account for 46.0% by 2020, a 43.8% increase.

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS IN TEXAS

According to the 2005-2006 National Survey of Children with Special Health Care Needs, 12.6% of children and youth in Texas under age 18 (806,746 children and youth) have special health care needs. Using data from 2007, the Annie E. Casey Foundation estimated the number of children with special health care needs in Texas to be 17.0% or over 1.1 million. According to the Casey Foundation data, Texas is second only to California in the estimated number of CYSHCN.

Moreover, Social Security Administration data from December 2008 reported that there were more than 112,875 children under the age of 18 in Texas that were blind or disabled and receiving Supplemental Security Income (SSI) benefits. Texas ranked third behind New York and California as having the greatest number of children receiving SSI.

When compared to the national average, Texas has a higher percentage of CYSHCN under age 18 living in poverty. According to the 2005-2006 NS-CSHCN almost 17% of Texas CYSHCN under age 18 live in households below 100% of the Federal Poverty Level (FPL), as compared to the national average of 15.7%, and 20.9% of Texas CYSHCN under age 18 live in households between 100 -- 199% FPL, as compared to the national average of 19.1%. In total, approximately 38% of Texas CYSHCN under age 18 live in households with incomes below 200% FPL.

POPULATION DENSITY

Considerable variations in population density exist throughout Texas, ranging from densely populated areas evidenced in the 25 metropolitan statistical areas to a rural area that has less than 25 people per square mile. The 10 counties with the greatest population density account for 57% of the Texas population with 13,533,994 inhabitants. Outside of these 10 counties, the average population density is 41 people per square mile. This presents a unique service delivery challenge of ensuring sufficient capacity to meet the demand in the most populated areas while also ensuring adequate access in more sparsely populated areas.

POVERTY IN TEXAS

Poverty underlies many health disparities in Texas. Poverty limits access to the "fundamental

building blocks" of health such as adequate housing, good nutrition, and the opportunity to seek health services when needed. Health disparities exist among various demographic groups in Texas, including differences across gender, race/ethnicity, education, income, or geographic location. The population groups with the highest poverty levels often have the poorest health statuses.

According to the 2006 American Community Survey, collected by the U.S. Census Bureau, an estimated 16.9% of individuals and 13.3% of families in Texas lived below the federal poverty level. The percentage of individuals living in poverty differed significantly by county, ranging from 4.9% in Rockwall County to 44.4% in Starr County.

More Hispanic and Black individuals lived in poverty (25.7% and 25.4%, respectively) than Whites (14.3%). Females were more likely than males to be living in poverty, 18.6% and 15.2%, respectively. Over 34% of female-headed households (no husband present) lived in poverty. In 2006, the poverty threshold for a family of four was $20,614.

Over 1.5 million of all Texans aged 18 and younger were living in poverty in 2006 (23.8%), ranging from 6.5% in Collin County to 55.4% in Zavala County. Of the 1.5 million Texan children living in poverty, 513,533 were younger than 5 years old (27.1%) and 977,059 were between the ages of 5 and 17 (21.7%).

In 2006, the median household income in Texas, which varied significantly by county of residence, was $44,943. Zavala County, at $18,719, had a median household income that was more than four times lower than the median household income in Rockwall County ($75,477).

UNEMPLOYMENT IN TEXAS

According to the U.S. Department of Labor, the percentage of individuals who were unemployed in 2008 differed significantly by county, ranging from 2.0% in Hemphill, Reagan, and Sutton Counties to 11.9% in Starr County. There were three other counties whose unemployment rate was greater than 10.0% in 2008: Zavala (10.8%), Presidio, (10.8%), and Maverick (11.0%). As of February 2010, Texas had the 19th lowest unemployment rate (8.2%) in the nation.

HEALTH DISPARITIES

Prematurity, low birth weight, SIDS, and consequently, perinatal and infant mortality, continue to be disparately high in the Black population compared to the White and Hispanic population in Texas. Racial/ethnic disparities in infant mortality rates are significant; with the rate among Black infants more than double that of White infants since 1998. In 2005, the rate of SIDS among Black infants was nearly three times that of White infants. The percent of Black babies born very low birth weight was approximately 2.5 times that of White and Hispanic babies.

In 2006, the maternal mortality rate in Texas was 17.8 deaths per 100,000 live births, which was 33.8% higher than the national rate of 13.3 deaths per 100,000 live births. The maternal mortality rate for Black women was 3.3 and 4.2 times higher than the rate for White and Hispanic women, respectively.

Between 2000 and 2008, 34.4% of women of childbearing age, on average, reported that they had no health care coverage. Among women with more than a high school education, the percent who had no health care coverage among Hispanic women was more than double that of White and Black women.

UNCOMPENSATED CARE

According to a report released by the Texas Department of State Health Services entitled, Charity Care Charges and Selected Financial Data for Acute Care Texas Hospitals, 2008, there was over

$13 billion dollars of uncompensated care in Texas in 2008. This accounted for 9.2% of the total gross patient revenue. Of this $13 billion, 44.9% was from bad debt and the remaining 55.1% was for charity care. Between 1999 and 2008, uncompensated care increased by nearly 179% in Texas. In 2008, 33.9% of the uncompensated care was provided by public hospitals, 44.5% was provided by nonprofit hospitals and 21.6% was provided by for-profit hospitals.

ACCESS TO CARE

According to the Texas Office of the State Demographer, there were approximately 1.5 million, or 24%, of the population birth to 17 years of age who were uninsured in 2010. Lack of health insurance coverage is one of the greatest barriers to children accessing health care in Texas and the subsequent lack of proper medical care for children can have serious economic repercussions for Texas.

With 61.5% of Texas counties designated as rural, access to primary and preventive health care services for about 2.0 million rural residents remains at risk. One hundred and nineteen counties (76.3%) of the state's 156 rural counties are designated Primary Care Health Professional Shortage Areas (HPSAs). Because of the lack of available primary care providers, such care is often delivered ineffectively and inefficiently.

Hospital emergency rooms often become clinics, a costly way to provide basic care. Without available primary care, rural residents lack an appropriate entry into the health care systems. The barriers to access to care described above may contribute to women not accessing prenatal care in a timely manner, not remaining in care for the duration of the pregnancy, or missing appointments due to reluctance to travel long distances or inability to pay for services.

Postpartum and inter-conception visits may also be delayed or skipped. After infants are born, well-baby checks and immunization visits may be missed or delayed, as well as other preventive and therapeutic physical and dental health visits for both women and children. When these visits are missed, there are fewer opportunities to observe and address developmental delays or health concerns in children that can ultimately lead to chronic problems or secondary disabilities. Limited access to care may also result in delays in identifying mental health issues during the post partum period and in obtaining effective treatment by mental health practioners.

DIRECT PATIENT CARE PHYSICIANS

In 2009, there were 39,374 direct patient care physicians in Texas. This number excluded federal and military physicians, residents, and fellows. There were approximately 158 direct patient care physicians per 100,000 people in 2009. Texas continues to see an increase in the number of direct patient care physicians in the state. Ten years ago, there were approximately 152 direct patient care physicians per 100,000 people. Despite these improvements, as of September 2009, 25 of the state's 254 counties had no direct patient care physicians, and 18 counties had only one practitioner.

A subset of direct patient care physicians, there were 16,830 primary care physicians in Texas in 2009. In 2008, the estimated population for Texas was 24.3 million. Of that, 8.1% of this population was located in 156 rural counties and 91.9% was located in the remaining 98 urban counties. In comparison, 5.9% of practicing primary care physicians were located in rural areas of the state, and 94.1% practiced in urban counties. Similarly, the 2008 estimated population in the border area accounted for 10.2% of the total population; however, only 7.5% of practicing primary care physicians resided in a border county.

Recruiting and retaining physicians in rural or border counties can be challenging. Because physicians' salaries in rural areas are often lower with a potentially higher work load than in urban areas, and fewer educational opportunities exist in rural areas, incentives (such as federal and state loan repayment programs) are used to help attract physicians into rural practice or along the

border.

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN) -SPECIFIC PROVIDER ISSUES

In 2009, there were 16,830 primary care physicians, and 26 counties did not have a primary care physician. In the area of pediatrics, there were 3,028 licensed pediatricians in Texas in 2009, and 137 counties without a pediatrician. This picture is complicated by the fact that, due to a variety of reasons, many physicians outside major medical centers are reluctant to provide ongoing care for children and youth with complex health care needs.

Many CYSHCN also require occupational therapy, physical therapy, audiology, and nutritional services. Recent data (2009) indicate shortages in a number of areas:

•There were 6,136 occupational therapists, and 91 counties had no occupational therapists.
•There were 10,016 physical therapists, and 49 counties had no physical therapists.
•There were 943 audiologists, and 182 counties had no audiologists.
•There were 3,930 registered dietitians, and 106 counties had no dietitians.

HEALTH PROFESSIONAL SHORTAGE AREAS (HPSA)

The combined diversity of Texas' demography and geography creates challenges related to adequate access to health services. Whole or partial counties can be designated as a HPSA by having a shortage of primary medical care, dental, or mental health providers.

Sparsely populated areas experience challenges in recruiting and retaining health professionals. Furthermore, supply shortages are not limited to rural areas. Some inner-city areas include pockets of shortage designation areas where primary care is unavailable as well. Although the number of providers may appear adequate in these areas, access is limited based on non-acceptance of Medicaid or a patient's inability to pay for services. The presence of providers does not necessarily equate to access for all residents.

In 2010, 189 of the 254 counties were recognized as having too few primary care physicians including family practitioners, general practitioners, pediatricians, internists, or obstetrician/gynecologists. Twenty counties (7.9%) were determined to be partial primary medical care HPSAs and 169 counties (66.5%) were whole primary medical care HPSAs. More than 19 million, or 78.4%, Texans reside in counties designated as whole or partial HPSAs. Of the total population living in the 189 county area, 39.3% of residents are Hispanic, with the largest concentrations along the Texas-Mexico border and in South Texas.

In 2010, 117 (46.1%) of the 254 counties were recognized as having too few dentists. Eight counties (3.1%) were determined to be partial dental HPSAs and 109 counties (42.9%) were whole dental HPSAs. More than 15 million (62.0%) Texans reside in counties with a whole or partial HPSA designation as dental shortage areas.

In 2010, 194 (76.4%) of the 254 counties were recognized as having too few mental health providers. Two counties (0.8%) were determined to be partial mental health HPSAs and 192 counties (75.6%) were whole mental health HPSAs. Nearly 14 million (57.2%) Texans reside in counties with a whole or partial HPSA designation as mental health shortage areas.

OTHER SHORTAGE AREAS

In 2010, there were 64 counties in Texas without an acute care hospital. As of January 2010, there were a total of 542 acute care hospitals in Texas. Of these 542, 66.9% were located in a metropolitan area. Nearly 44% of all hospitals (235) had fewer than 50 hospital beds. There

were 63 counties with no physician assistants; 43 counties without a dentist; 59 counties without nurse practitioners; 40 counties without social workers; and 203 counties with no nurse midwives.

TEXAS TITLE V AGENCY DESCRIPTION

The Department of State Health Services (DSHS), which administers Title V, is the state agency responsible for oversight and implementation of public health and behavioral health services in Texas. Its mission is "To improve health and well-being in Texas." With an annual budget of $2.9 billion and a workforce of approximately 12,500, DSHS is the fourth largest of Texas' 178 state agencies. DSHS manages nearly 5,400 client services and administrative contracts and conducts business in 157 locations.

In Texas, Title V operates within the strategic plan framework articulated by Texas State Government; the Health and Human Services Commission (HHSC), the state agency responsible for leading and overseeing the health and human services agencies and ensuring that they function as a system; and DSHS. DSHS operations began September 1, 2004, as a result of the passage of House Bill 2292 during the 78th Texas Legislative Regular Session (2003). This legislation established a clear directive to transform the delivery of health and human services in Texas. The consolidation of 12 agencies into a network of 4 new departments under the leadership of HHSC was designed to improve services, increase efficiency, and enhance accountability among the state's health and human service agencies. DSHS consists of the former Texas Department of Health, the Texas Commission on Alcohol and Drug Abuse, the Texas Health Care Information Council, and the community mental health services and state hospital programs formerly operated by the Texas Department of Mental Health and Mental Retardation. This consolidation presented opportunities to integrate primary health care and behavioral health care in an effort to provide a more holistic approach to service delivery.

DSHS promotes optimal health for individuals and communities through the provision of effective public health services, clinical services, mental health services, and substance abuse services. Responsibilities include coordinating a statewide network of services available through DSHS and its partners, ranging from whole population-based services to individual care. In its efforts to improve health and well-being in Texas, DSHS has the following four priority goals:

•Protect and promote the public's health by decreasing health threats and sources of disease;

•Improve the health of children, women, families and individuals, and enhance the capacity of communities to deliver health care services;

•Promote the recovery of persons with infectious disease, substance abuse and/or mental illness who require specialized treatment; and

•Achieve a maximum level of compliance by regulated entities in order to protect public health and safety.

Title V is an important component in achieving the DSHS mission and priority goals. The following statewide benchmarks relevant to the mission and priority goals are also consistent with Title V requirements and outcome and performance measures:

•Number of children served through the Texas Health Steps Program (Medicaid EPSDT);

•Percentage of Texas children in kindergarten who are completely immunized according to school immunization requirements;

•Infant mortality rate;

•Low birth-weight rate;

•Teen pregnancy rate;

•Percentage of births that are out-of-wedlock;

•Number of women served through Title V prenatal care services;

•Percentage of screened positive newborns who receive timely follow-up after newborn screening;

•Rate of substance abuse and alcoholism among Texans;

•Number of women served through the Texas Breast and Cervical Cancer Program;

•Number of Federally Qualified Health Centers (FQHCs) since the inception of the Texas FQHC Incubator Program; and

•Number of people who receive mental health crisis services at community mental health centers.

1) PREVENT AND PREPARE FOR HEALTH THREATS

DSHS is responsible for improving health and well-being in Texas by implementing programs that decrease health threats and sources of disease and enhance state and local public health systems' resistance to health threats and preparedness for health emergencies. This function includes the prevention of chronic and infectious diseases, including those associated with public health emergencies. The function also includes epidemiological studies and registries designed to provide the state with the basic health care information it needs for policy decisions, to address a particular disease, and to identify cases of disease for program evaluation and research. Within this agency priority goal, Title V has responsibility for:

a. Community Preparedness -- Title V staff provides support to all agency-wide planning, training, and response to a natural disaster, disease outbreak, biologic attack, or other public health emergency.

b. Health Promotion and Vital Records -- Title V staff work closely with DSHS programs, such as the Center for Health Statistics, Cancer Registry, and Vital Statistics, that are charged with the collection and provision of health information needed to make state and local policy decisions and to evaluate interventions related to health status improvement. In addition, Title V provides a portion of funding to the Texas Birth Defects Registry to identify and describe the patterns of birth defects in Texas. Tracking this data provides information on the types of birth defects that are occurring, how often and where they occur, and in what populations they are occurring. This information can be used to identify the causes of birth defects, implement effective prevention and intervention strategies, and refer affected children and their families to medical and social services.

c. Immunizations -- DSHS immunization activities improve quality of life and life expectancy by achieving and maintaining an environment free of vaccine-preventable diseases. Title V staff promote the use of ImmTrac, the statewide immunization registry; educate providers and the public about immunization strategies and their public health value; and work with stakeholders to implement and improve immunization activities. In 2009, Texas was recognized by the CDC as the most improved state in immunization coverage levels, ranking 12th in the nation.

d. HIV and Sexually Transmitted Disease Services (STD) -- The HIV/STD Program works to increase the number of Texans who know their HIV/STD status, reduce the number of HIV-infected persons who have unmet needs for medical care, and educate individuals about risk of

HIV/STD issues. Title V staff support these activities through educating stakeholders and communities as well as ensuring access to services through the development of clinical policies carried out by contracted direct service providers or through referrals.

e. Health Promotion and Chronic Disease Prevention -- Title V provides staffing and funding resources to several programs that promote health and lower the incidence of chronic disease or other unwanted health conditions. Partnerships focus on educating individuals on healthy life choices (i.e., physical activity and dietary habits), enhancing infrastructure for school-based health education and direct health care services, and outreach and community engagement to create healthy and safe environments (i.e., injury prevention and youth-focused development).

f. Laboratory Services -- The DSHS public health laboratory provides analytical, reference, research, training, and educational services related to laboratory testing. Title V supports laboratory services such as analytical testing and screening services for children and newborns and diagnostic testing for Title V-funded direct service providers.

g. Regional and Local Public Health Services -- The purpose of the local and regional public health system is to safeguard Texans' health by performing preventive, protective, and regulatory functions and effectively responding in an emergency or disaster. In the absence of local health departments or authorities, DSHS health service regions (HSRs) perform critical functions related to public health and preparedness, as well as working to reduce or eliminate health disparities in the state. Title V provides staffing and funding resources through HSRs to conduct activities such as health education, promotion, and assessment of health disparities; working with communities and local officials to strengthen and maintain the local public health infrastructure; planning for and responding to local public health emergencies such as H1N1 or hurricanes; identifying populations with barriers to health care services; evaluating public health outcomes; and enforcing local and state public health laws. See Attachment III. A. Overview -- DSHS HSR Map for a map of the HSR designations.

2) BUILD CAPACITY TO IMPROVE COMMUNITY HEALTH

DSHS seeks to ensure that Texans have access to the most fundamental health services, prevention, and treatment across the state, through contracts with providers. These services include primary health care, mental health care, and substance abuse services. DSHS also works through the Women, Infants, and Children (WIC) program to ensure that good nutrition is accessible to Texans who are younger than five years of age or are women who are pregnant, breastfeeding, or post partum. Finally, DSHS works to build health care capacity in communities by providing technical assistance and limited funding to organizations applying for certifications and to health care providers to assist in repaying educational loans. Within this agency priority goal, Title V has responsibility for:

a. Women's Health Services -- Title V provides funds for a wide range of activities that administer and facilitate the statewide, coordinated delivery of preventive, comprehensive health care services to low-income women. Through a competitive process, contracts are awarded to direct service providers across the state to provide family planning, prenatal care, genetics services, dysplasia services, laboratory services, and case management to high-risk pregnant women.

b. Children with Special Health Care Needs Services Program (CSHCN SP) -- CSHCN SP, in part financed through Title V funding, supports family-centered, community-based strategies to improve the quality of life for eligible children and their families. The program covers health care benefits for children with extraordinary medical needs, disabilities, and chronic health conditions. Health care benefits include a broad array of medical care and related services. The program contracts with community-based organizations in many parts of the state to provide case management, family support, community resources, and clinical services. The program also provides case management services through DSHS staff based in eight regional offices. Developing and increasing access to a medical home is a key initiative of CSHCN SP. Program

staff actively collaborate with consumers, providers, other state agency staff, and interested stakeholders to ensure a system of care is in place to meet the needs of CYSHCN.

c. Child and Adolescent Health Services -- Title V funds a wide range of activities that administer and facilitate the statewide, coordinated delivery of preventive, comprehensive health care services to low-income children and adolescents. Through a competitive process, contracts are awarded to direct service providers across the state to provide well- and sick-child visits, dental care, family planning, dysplasia detection, laboratory services, and case management to high-risk infants.

d. Community Capacity Building -- Title V is structurally organized to provide administrative oversight to services that develop and enhance the capacities of community direct service providers. One example is the Federally Qualified Health Center (FQHC) infrastructure grants that assist in the development of new or expanded FQHCs. Another example is the recruitment and retention of health care professionals through a cooperative agreement funding from HRSA. The program focuses on clinics that are located in health professional shortage areas and medically underserved areas. The federal funds also support activities that measure access to health care services and designate these as provider shortage areas and medically underserved communities. Related to professional shortages, the Children's Medicaid Loan Repayment Program, Physician Education Loan Repayment, and Dental Education Loan Repayment programs all provide incentives to physicians and dentists who agree to serve an underserved target population in Texas, and receive loan repayment funds for these services. Also within the administrative oversight of Title V, the Promotora/Community Health Worker (CHW) Training and Certification Program coordinates the training and certification process for becoming a certified promotora/CHW to provide outreach, health education, and referrals to local community members.

e. Population-Based Activities -- Title V supports population-based services, such as screening Texas' children for health needs related to vision and hearing, spinal abnormalities, newborn hearing loss, and newborn diseases. Title V-funded programs also promote adolescent health, breastfeeding, tobacco cessation, car seat safety, safe sleep for infants, and fluoridation of drinking water supplies across Texas. For example, Title V staff developed and funded a new initiative focused on healthy adolescent development, using community-based coalitions across the state. In addition, staff design and distribute outreach materials to educate and train parents, child care providers, and early childhood professionals on health and safety issues. Finally, HSR staff work with stakeholders to address injury prevention, childhood obesity, access to care, and teen pregnancy efforts unique to their respective regions.

f. Infrastructure Building Activities -- Title V supports data collection and dissemination efforts such as child fatality review teams and the Pregnancy Risk Assessment Monitoring System; statewide provider training related to suicide prevention and car safety seats; and collaboration among partners throughout the agency and with external stakeholders on variety of MCH issues. Support is also provided to staff that develop policies and standards for the provision of direct services, monitor for contractor compliance with the established standards, and provide technical assistance to direct service contractors.

3) PROMOTE RECOVERY FOR PERSONS WITH INFECTIOUS DISEASE, SUBSTANCE ABUSE AND/OR MENTAL ILLNESS

DSHS promotes surveillance, education, epidemiology, consultation, and intervention for persons with infectious disease. DSHS is also responsible for improving the health and well-being of Texans across the life-span through substance abuse prevention, mental health promotion, and behavioral health treatment to persons with mental illness or substance abuse issues. As the state mental health authority, DSHS manages contracts with 38 community mental health centers across Texas. DSHS also provides substance abuse treatments services through community organizations that contract with the state.

Title V efforts regarding this agency goal continue to focus on the integration of mental health and substance abuse services into the primary health care setting. For example, Title V staff have convened a inter-agency workgroup to develop best practice guidelines related to domestic violence, substance abuse, mental health, and perinatal health for a variety of provider settings. The tools will assist providers in identifying and determining need and provide guidance regarding intervention techniques and appropriate referral, if necessary.

4) PROTECT CONSUMERS THROUGH LICENSING AND REGULATORY SERVICES

DSHS seeks to protect the health of Texans by ensuring high standards in the following areas: health care facilities, health care-related professions (excluding physicians and nurses), EMS providers and personnel, food and food preparation, pharmaceuticals, medical and radiological devices, and consumer products. This function establishes regulatory standards and policies, conducts compliance and enforcement activities, and licenses, surveys, and inspects providers of health care services.

In relation to this priority goal, Title V funded staff provide administrative oversight to the Community Health Worker/Promotora Training and Certification Program. This program works to enhance the development and implementation of statewide training and certification standards for this paraprofessional workforce in Texas. Additionally, Title V staff are beginning efforts to partner with the DSHS Regulatory Services Division to explore avenues to improve data collected and reported to HRSA concerning the percent of very low birth rate infants delivered at facilities for high-risk deliveries and neonates.

AGENCY-WIDE CHALLENGES TO CAPACITY

A recent agency-wide internal assessment identified key factors that impact DSHS' capacity to improve the health and well-being of all Texans. These factors are similar to those identified in the FY11 Five-Year Needs Assessment for serving the MCH population and include challenges in available and sustainable funding, information technology, and workforce development.

As a state agency, DSHS' budget and staffing levels are determined by the Texas Legislature. Consequently, DSHS must operate with the resources allocated. DSHS has decreased staffing and spending levels to meet mandated budget reductions, while making every effort to minimize the impact on services. Economic downturns have lead to both an increased demand for services and a simultaneous decrease in the financial resources available to address the increased needs. Population growth and risk behaviors further contribute to an escalating need for services. DSHS is working with other federal, state, and local entities to leverage available resources in order to respond to these growing needs.

DSHS Information Technology is in a state of transition from a largely reactive, silo-based, hardware driven environment to a proactive, service delivery focused and data driven infrastructure. Increased focus is being placed on building capacity in the availability, quality, accessibility, security, and sharing of agency data. The systems currently being re-engineered or remediated all include requirements for web-enabling, standards-based architecture, federal and state rules compliance, and inter-operability for data sharing. Strategic initiatives will include evaluations of business intelligence software, e-discovery software, mobile applications strategies, and the use of field data collection and reporting applications utilizing smart phones. Focus is also being placed on broad adoption of electronic health records and electronic medical records. Heightened requirements for interoperability, exchange, data protection, and security will result in shorter technology refresh cycles as the health care industry evolves in response to recent reform. The DSHS technology infrastructure once perceived as a helpful tool for public health practice in Texas is now essential and required.

Surging population growth, shifting demographic trends, and an aging workforce create

challenges in maintaining and developing an efficient, effective, and well-trained workforce who are vital to protecting and improving the health and well-being of Texans. In addition, other potential changes in the labor market could jeopardize the acquisition, development, and retention of a current competent workforce. DSHS must continue to collaborate with institutions of higher education to attract candidates with specialized education and training in public health. Continued efforts must support critical training needs in technical areas to enhance and sustain a skilled staff fully engaged in the operations of the organization. The ability to survive competition in other sectors of the labor market will rest upon comprehensive strategic initiatives and optimizing workforce management resulting in the successful performance of the agency's mission.

These challenges will continue to be explored and activities have been and will be developed to strengthen those areas within the context of DSHS' responsibilities as the public health agency, the potential changes in health care systems, and the state budget over the next five-year period.

An attachment is included in this section.

B. Agency Capacity

STATEWIDE SYSTEM OF SERVICES

DSHS' focus on physical and behavioral health provides the agency with a broad range of responsibilities associated with improving the health and well-being of Texans, including the health of all women and infants, children and adolescents, and CYSHCN . This mission is accomplished in partnership with numerous academic, research, and health and human services stakeholders across the nation, within Texas, and along the U.S./Mexico border. Service system partners such as DSHS Health Service Regions (HSRs), DSHS hospitals, Local Mental Health Authorities, Federally Qualified Health Centers (FQHC), local health departments, and contracted community service providers serve an important role in working collaboratively to address existing and future issues faced by the agency. Therefore, DSHS actively promotes communication, coordination, and cooperation with these agencies. Where there is a potential for overlap or duplication of functions, DSHS works with other agencies to define roles and responsibilities, establish agreements, and clarify services and client populations to minimize duplication.

Services to improve community health which are provided by DSHS differ from health services provided by other agencies in that they target prevention; that is, they focus on education, technical assistance to providers, and preventive services that impact whole families. Rather than focusing exclusively on providing access to a full range of health care services, DSHS programs provide services that are designed to reach populations, not just individuals, and to prevent disease and minimize the need for future medical interventions. DSHS communicates and collaborates closely with other federal, state, and local health and human service agencies, particularly those that serve similar populations.

The statutory governance and organizational structure of DSHS in the state plays a determining role in the way many of these functions are performed. For example, because Texas is a "home-rule" state, the local health officials operate autonomously from, but in partnership with, DSHS. Furthermore, HHS agencies produce a single plan addressing opportunities and challenges shared across system in the "Coordinated Strategic Plan for Health and Human Services." This document ensures coordination between HHS agencies by providing a single, coordinated plan for the statewide delivery of services. The plan for state fiscal years 2009-2013 may found at the following website: http://www.hhs.state.tx.us/StrategicPlans/HHS09-13/StrategicPlan_FY2009_2013.pdf.

Coordination of statewide services is also achieved through Community Resource Coordination Groups (CRCGs) that organize services for children and youth who have multi-agency needs and

require interagency collaboration. HHSC provides state level coordination of CRCGs. Organized by counties, some CRCGs cover several counties to form one multi-county group, while others cover a single-county. CRCGs help people whose needs cannot be met by a single agency. Composed of a variety of public and private agencies in an area, CRCGs provide a way for individuals, families, and service providers to prepare action plans that address complex needs of HHS System consumers. The groups can include representation from the HHS System agencies, the criminal or juvenile justice system, the education system, housing agencies, the workforce system, local service providers, and families.

TEXAS STATUTES RELEVANT TO TITLE V

Select Texas statutes pertaining to the provision of services to MCH populations includes:

Services to CYSHCN -- CSHCN SP is authorized under Texas Health and Safety Code SS35.001--35.013 which states that the program shall provide 1) early identification; 2) diagnosis and evaluation; 3) rehabilitation services; 4) development and improvement of standards and services; 5) case management services; 6) other family support services; and 7) access to health benefits plan coverage. CSHCN SP rules expand on the details of the above services.

Newborn Screening -- The Texas Legislature first passed legislation in 1965 establishing the Newborn Screening Program. The law requires that all newborns who have been screened and found to be presumptively positive for heritable diseases receive follow-up. Since initial passage, subsequent legislation has revised the program to increase the number of disorders screened to the current total of 28. Cystic Fibrosis was most recently added to the screening panel in December 2009.

Newborn Hearing Screening Program -- Established in 1999 through the passage of House Bill 714, the program is currently being implemented in Texas hospitals offering obstetrical services. DSHS is the oversight agency identified in Chapter 47 of the Health and Safety Code. The purpose is to ensure all children who have hearing loss as newborn infants or young children are identified early and provided appropriate intervention services needed to prevent delays in communication and cognitive skill development.

Birth Defects Monitoring -- In 1993, the Texas Legislature established the Birth Defects Epidemiology and Surveillance program for the purpose of identifying, investigating, and monitoring birth defects cases in Texas. The program is required to provide information to identify the risk factors and causes of birth defects, support the development of strategies to prevent birth defects, and maintain data in a central registry.

Immunizations -- Also in 1993, a childhood immunization law was passed to mandate age-appropriate immunization of every child in Texas. Exclusions from compliance are allowable on an individual basis for medical contraindications, reasons of conscience, including a religious belief, and active duty in the U.S. Armed Forces.

Sudden Infant Death Syndrome (SIDS) -- Texas law requires that the death of a child 12 months old or younger be reported to the Justice of the Peace, medical examiner, or other proper official if the child dies suddenly or is found dead and the cause is unknown. If SIDS is determined as the cause of death, the law directs DSHS to reimburse the county a fixed sum for the cost of the autopsy.

Child Fatality Review -- Child Fatality Review Teams (CFRT) are authorized under Texas Family Code SS264.501-264.515. The State Committee is a multi-disciplinary group of professionals selected from across the state with a membership reflecting the geographical, cultural, racial, and ethnic diversity of the state that works to understand the causes and incidence of child deaths in Texas; identify procedures within the representative agencies to reduce the number of preventable child deaths; and increase public awareness and make recommendations to the

governor and legislature for effective changes in law, policy, and practices.

Child Passenger Safety -- Recent legislation requires children younger than 8 years old, unless they are 4 feet 9 inches in height, to be properly restrained in a child passenger safety seat while riding in an operating vehicle.

Public Education Resources -- Various statutes direct DSHS to develop informational and educational materials on topics including, but not limited to, shaken baby syndrome, perinatal depression, newborn screening, immunizations, safe sleep, teen pregnancy, umbilical cord blood banking and donation, lead poisoning, and injury prevention.

DSHS TITLE V CAPACITY

A. Overview of Programs and Services

Title V staff and funding resources are a key element in DSHS' capacity to provide primary and preventive care to the Texas MCH population. Program activities typically include systems development, infrastructure, contract development and support, policy and procedure development, technical assistance, training, and quality assurance to local community organizations working to improve the health of the MCH population.

Please see a full description of agency capacity as it appears in the FY11 Five-Year Needs Assessment.

1) Services for Women, Infants, Children, and Adolescents

The majority of Title V services are provided through contracts with local providers including city/county health departments, hospital districts, school districts, FQHCs, non-profit agencies, and individual providers. Contracts are awarded through a competitive request for proposal process that typically includes a three- to five-year renewal period after the first year of implementation. Many of these providers also contract with DSHS for the provision of other services such as WIC, Title X and/or XX family planning, breast and cervical cancer screening/diagnosis, Texas Health Steps (EPSDT), and HIV/STD.

Direct and enabling health care services are provided to women, children, and families who are not eligible for the same services through other programs such as Medicaid and CHIP and who are at or below 185% FPL. Title V-funded providers are required to screen for Medicaid/CHIP eligibility and to assist those individuals who are potentially eligible with the Medicaid/CHIP application forms. To ensure continuity of care during and after the eligibility determination process, Title V-funded providers must also be enrolled as Medicaid providers. Typically, Title V reimburses contractors for services provided using Medicaid reimbursement rates. If a client that received services paid with Title V funds is later found to be Medicaid/CHIP eligible through the eligibility determination process, contracted providers are able to recoup payment from Medicaid/CHIP for those services and restore funding to Title V.

The majority of laboratory testing services for Title V clients are completed through DSHS laboratory facilities. Otherwise, contractors are reimbursed by Title V using standard rates if testing is completed on-site or by a private laboratory.

Title V-funded staff participate in monitoring, onsite reviews, and quality improvement activities of contracted service providers with respect to MCH services, standards, and regulations.

Preventive and primary care services for women, pregnant women, and infants include:

Prenatal Services -- In coordination with CHIP Perinatal, includes up to two initial visits; ultrasound; nutrition education; laboratory testing; and high-risk case management.

Family Planning Services -- Comprehensive health history and physical exam; laboratory testing such as screenings for cervical cancer, sexually transmitted infections, cholesterol, blood glucose, and pregnancy; provision of contraceptive methods, counseling, and education; treatment of sexually transmitted infections.

Dysplasia Services -- Initial and follow-up visits; diagnostic and therapeutic procedures such as colposcopy, biopsy, cryotherapy, and LEEP.

Genetics Services -- Detailed family genetic health history; physical examination; laboratory testing; and counseling and case management.

Well-Child Services -- Well and sick child initial and return visits; immunizations; nutritional counseling; and high-risk case management.

Newborn Screening -- Testing for 28 disorders; follow-up and case management to ensure abnormal results receive confirmatory testing and treatment, if needed.

Newborn Hearing Screening -- Testing for hearing impairment; follow-up, diagnostic evaluation, and linkage to intervention services, if needed.

Breastfeeding Support -- Initiatives that promote, support, and educate on the benefits of breastfeeding including a Mother Friendly Worksite designation for businesses that have a written policy that supports breastfeeding employees and customers, Texas Ten Steps Facility designation for hospitals that support breastfeeding in new mothers delivering at the facility, and support for mother-to-mother drop-in centers in local communities for breastfeeding women.

Healthy Start Collaborative -- Support for population-based activities conducted in six Healthy Start sites in Texas focused on immunizations, breastfeeding, diabetes, folic acid promotion, early prenatal care, and child safety.

Rape Prevention and Education -- Collaborative efforts to support the primary prevention of sexual assault and/or violence through public education and professional development.

Preventive and primary care services for children and adolescents include:

Child Health and Dental Services -- Includes well-child, limited acute care, and follow-up visits; immunizations; nutritional counseling; laboratory testing; periodic oral evaluation, fluoride treatments, sealants, and extractions; and high-risk case management.

Texas Health Steps -- Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT) providing comprehensive medical and dental prevention, treatment, and case management for Medicaid-eligible children from birth through age 20.

Vision and Hearing Screening -- Annual screening for children 4 years of age through 9th grade who are enrolled in a licensed child care facility, group day care home, or public/private school.

Spinal Screening -- Screening for abnormal spinal curves for 6th and 9th grade students attending public/private school.

Lead Screening -- Screening for elevated blood lead levels for children younger than 15 years of age.

School Health Program -- Development of comprehensive school health education and school-related health care services statewide through a school health network and school-based health centers.

On-line Training Modules -- Web-based, no-cost training to child care providers on a variety of child health issues such as safe sleep, infection control, injury prevention, nutrition, and physical activity.

Obesity Prevention -- Collaborative efforts that support community-based initiatives addressing physical activity and nutrition; a tool kit for school nurses (Get Fit Kit) to use with adolescents identified as overweight or obese through the state's physical assessment test.

Texas Healthy Adolescent Initiative -- Support for local communities to address adolescent health through an evidence-based comprehensive youth development approach.

Oral Health -- Provision of direct preventive dental services to targeted populations through 5 regionally-based dental teams; promotion and monitoring of water fluoridation in the state.

State Child Fatality Review -- Provides assistance, direction, and coordination to investigations of child deaths; identifies local child safety issues; makes recommendations on changes to law, policy, or practice to promote child safety.

DSHS Title V Population-Based Regional Staff -- Conduct regional population-based activities focused on four priority areas: obesity, access to care, injury prevention, and teen pregnancy; participate on local CFRTs.

Infrastructure building activities that support systems capacity for all MCH populations include:

Leadership Education in Adolescent Health (LEAH) -- Partnership to provide interdisciplinary leadership training, faculty development, continuing education, and technical assistance to develop workforce capacity around MCH health issues.

Promotora/Community Health Worker Training and Certification Program -- Provides leadership to enhance the development and implementation of statewide training and certification standards and administrative rules for the provision of outreach, health education, and referrals by this group of community-based paraprofessionals.

Office of Academic Linkages -- Identifies as supports partnerships between DSHS and academic institutions; helps to develop the statewide health-related workforce through continuing education opportunities, grand rounds presentations, residency training program, and nursing leadership coordination.

Centers for Program Coordination, Policy, and Innovation -- Supports agency-wide issues and service integration related to policy analysis and assessment; process improvement; project management; coordination with Medicaid; and rule process coordination.

Office of Border Health -- Works to enhance efforts to promote and protect the health of border residents by reducing community and environmental health hazards along the Texas-Mexico border.

HHSC Office of Elimination of Health Disparities -- Provides technical assistance to HHS agencies to ensure that health disparities are addressed in services provided to increase capacity for improving health status; provides internal and external leadership via collaborative development of health policies and programs that will eliminate health disparities; and promotes cultural competency, research, health literacy and evaluation of health promotion and disease prevention program activities.

Data Collection and Surveillance -- Data collection, research, and evaluation support for Title V activities; a number of surveys/systems are used to collect MCH data: Pregnancy Risk

Assessment Monitoring System, Texas Infant Sleep Study, WIC Infant Feeding Practices Survey, School Physical Activity and Nutrition Survey, State Systems Development Initiative, Birth Defects Monitoring, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Cancer Registry, and Vital Statistics.

2) Services for CYSHCN

DSHS and other HHS agencies provide a broad range of supports for CYSHCN and their families. The newly formed statewide Task Force for Children with Special Needs will further define available community services and supports to develop a strategic plan to improve care for CYSHCN and their families.

Despite the opportunity to address improvement in services, state funding limitations have the potential to impact communities. As an example, the Department of Assistive and Rehabilitative Services (DARS) Early Childhood Intervention (ECI) program announced that services may be reduced. Information gathered from statewide stakeholder meetings by DARS will help legislators as they consider the agency's ECI funding request.

Title V federal and state funds support the efforts of CSHCN SP. The program uses a competitive bid process to fund 25 community-based services contractors who provide case management, family supports and community resources, and clinical supports to CYSHCN and their families.

Title V funded CSHCN SP initiatives include collaboration with the Leadership Education in Adolescent Health (LEAH) project at Baylor College of Medicine to advance and improve transition services, an analysis of Permanency Plans for youth in congregate care by EveryChild, Inc., seed money grants of up to $20,000 for practices to improve medical home services, and support for the Texas Medical Home Initiative pilot project.

CSHCN SP's health care benefits help numerous CYSHCN from communities throughout Texas access health care. In FY09, the program provided health care benefits to 2,377 clients. Health care benefits include family support services, such as respite and home and vehicle modifications. There is a waiting list for the program's health care benefits. However, the program provides case management services through HSR staff and contractors for all clients, including those on the waiting list for health care benefits.

Much of the coordination of health services with other services at the community level is supported through the infrastructure of the CRCGs and DSHS HSR and contractor case management staff. However, community-based services organizations are the true core infrastructure operating in the state. State staff partner with some of these organizations through formal contractual arrangements, electronic mailing list communications, participation in organizational meetings, and participation/presentations at conferences, etc.

Texas Parent to Parent (TxP2P) is the federally-funded Family-to-Family Health Care Education and Information Center. CSHCN SP contracts with TxP2P to provide family support and community services in Harlingen and Dallas. CSHCN SP staff participate in annual parent conferences as speakers, planners, and exhibitors. TxP2P participates in the Medical Home Work Group (MHWG) and provides medical home trainings to professionals and parents throughout the state. Their electronic mailing list communications enable information to be shared with families across Texas.

TxP2P and the other community-based services contractors were instrumental in generating parent input in the Title V CYSHCN Five-Year Needs Assessment process. CSHCN SP staff has collaborated with Texas Education Agency, Education Service Centers, DARS, and Independent Living Centers to promote and improve transition services for CYSHCN in Texas. Staff has taught health transition curricula in the Independent Living Center classroom settings. New partnerships in the areas of education, employment, and adult living are emerging through the collaboration of

CSHCN SP staff with other state agency and local organization staff.

The 2-1-1 Texas system improves access and coordination of community-based services and allows callers to find out about health care and other services in their local areas. 2-1-1 serves a vital role in the emergency/ disaster evacuation and planning activities for people with disabilities. CSHCN SP promoted emergency planning and preparedness through the program's bilingual Family Newsletter and Provider Bulletins. Program staff prepared a Spanish language translation of the American Academy of Pediatrics Emergency Information Form (EIF), incorporating commonly used regional idioms. The program encourages community-based services contractors to promote use of the EIF among families of CYSHCN and requires that all practices receiving medical home supports seed money grants increase the numbers of CYSHCN in their practices who have completed the EIF.

Family Voices representatives in Texas are key advocates and spokespersons for improving access to and coordination of health and other services for CYSHCN and their families at the local, regional, state, and national levels. CSHCN SP collaborates with each of these individuals and their projects as well as other parents of CYSHCN and benefits from their expertise and guidance. All participate in the MHWG and all are active in providing community-based services to CYSHCN and their families.

a. Rehabilitation services for CYSHCN receiving SSI

CSHCN SP provides outreach to SSI eligible clients to determine need for case management services. SSI-eligible children in Texas receive Medicaid coverage, providing health care benefits. CSHCN SP provides back-up, gap-filling health benefits coverage if a child receiving SSI loses those benefits due to an extra pay period that causes the family to exceed the SSI income limitations in a single month. Community-based contractors and DSHS case management staff may assist CYSHCN in applying for SSI benefits.

CSHCN SP actively seeks to engage stakeholders in the decision-making process. The program has strengthened ties with the TxP2P organization and collaborates with their efforts to educate parents and caregivers. CSHCN SP funded TxP2P's expansion of services, which includes three distinct geographic areas of Texas. Parents of CYSHCN in various geographic locations have become Family Voices representatives to improve statewide involvement of families in systems development. DSHS regional social work staff and the program's community-based service contractors work to facilitate family access to services, promote family networking, increase family involvement in community service system development decisions, and obtain family feedback.

b. Family-centered, community-based, coordinated care for CYSHCN

CSHCN SP's community contractors provide health care benefits that include a broad array of services that support children and their families.

CSHCN SP will continue to provide leadership in coordinating development and promotion of medical homes through the MHWG whose membership includes representatives from state agencies, family members, advocates, and private providers. The MHWG meets quarterly to report on efforts of agencies and groups and to continue work on the strategic plan to educate providers and families and promote the development of medical homes.

CSHCN SP collaborates with the Medicaid (Title XIX), and CHIP (Title XXI) programs by providing "gap-filling" services as needed for CYSHCN. As noted above, some children lose Medicaid eligibility certain months due to income, in which case the CSHCN Services Program may be able to provide health care benefits.

B. Culturally Competent Care

Health disparities exist among various demographic groups in Texas, including differences across gender, race/ethnicity, education, income, or geographic location. For example, health disparities between Texans living along the border with Mexico and those in non-border communities have long been a concern for public health.

Activities funded by Title V include an expectation that all staff have a working knowledge of cultural competence and the ability to conduct their work in a manner that shows consideration for racial and ethnic differences and for clients with physical, emotional, and mental disabilities. DSHS works to ensure cultural competence from its contractors through contract assurances, training, and quality assurance monitoring. Title V Request for Proposals (RFPs) include a set of assurances and certifications towards limited English proficiency, interpreter services, and non-discrimination with which each contractor agrees to abide. Morbidity, mortality, and population-in-need data is used to determine regional funding allocation for direct service programs to ensure resources are available to the areas of the state most in need.

Most educational materials for children and women are published or made available in at least English and Spanish, and frequently in other languages based on need. Referral information provided through 2-1-1 Texas is provided 24 hours a day, 7 days a week in multiple languages. In many cases, there are Spanish speaking operators. For the other languages, 2-1-1 Texas contracts with either Tele-Interpreter or the AT&T Language Line. Services are also available through text telephone or TTY for people with hearing impairments.

CSHCN SP proactively works to ensure cultural competence. Bilingual (English and Spanish) and bicultural program staff operate a toll-free line for use by persons applying for and/or receiving the program's health care benefits. In addition, regional case management and eligibility staff are bilingual. Regional offices also use Language Line Services to assist with communication in multiple languages other than English and Spanish. The FY09 Medical Home Support grants strengthened infrastructure and enhanced use of translation programs for clinics.

The program's written communications with its clientele always are done in both English and in Spanish; the program's Web site is available in both English and Spanish; and the program also has many educational materials published in Spanish. CSHCN SP staff works to ensure that contractors are able to communicate with clients in languages other than English. The CSHCN SP Family Newsletter is published in English and Spanish and, in FY09, included an article on respectful language, modern terminology, e.g. "intellectual disabilities".

In its ongoing efforts toward cultural competency, CSHCN SP continues to seek opportunities to include input from statewide and regional groups and committees with family members who are both bicultural and bilingual. As discussed earlier, the CSHCN SP family needs assessment surveys were prepared in both English and Spanish. The program's service contractors are grassroots organizations serving communities throughout Texas and their leadership and advisory groups reflect the cultural make-up of the populations they serve, and their consumer satisfaction surveys are bilingual. CSHCN SP staff present at and attend multicultural events to include the Annual African-American Family Support Conference and Annual Symposium of the Texas Association of Healthcare Interpreters and Translators.

CSHCN SP staff partnered with Texas Health Steps to update the Cultural Competency online training module and developed activity plan output measures that require CSHCN SP staff and contractors to complete the training module. The new activity plan reads: to "enhance and promote the use of People First language and use of appropriate languages, literacy levels and cultural approaches in all communications with CYSHCN and their families".

Since FY09, all CSHCN SP central office staff and program contractors were required to complete the Cultural Competency training module and has attained a 100% completion rate.

C. Organizational Structure

Please refer to Attachment III. C. Organizational Structure for agency organizational charts effective June 2010.

Texas has a plural executive branch system with power divided among the governor and independently elected Executive Branch officeholders. Except for the Secretary of State, all executive officers are elected independently, making them directly answerable to the public rather than the governor.

The Texas Legislature has a House of Representatives with 150 members, while the Senate has 31 members. The Speaker of the House leads the House and the Lieutenant Governor leads the Senate. The Legislature meets in regular session once every two years (odd-numbered years).

During the interim, the Legislative Budget Board (LBB) is one of several statutory bodies that provide direction to state agencies. This 10 member permanent joint committee of the legislature develops budget and policy recommendations for funding appropriations to all state agencies, and completes fiscal analyses for proposed legislation. The joint-chairs are the Lieutenant Governor and the Speaker of the House.

The Health and Human Services Commission (HHSC) was created by the 72nd Texas Legislature (1991) to provide leadership and strategic direction for Texas' Health and Human Services (HHS) System. The responsibilities of HHSC have grown substantially since inception resulting in enhanced oversight of the HHS System. Governor Rick Perry named Mr. Thomas Suehs as the HHSC Executive Commissioner to replace retiring Executive Commissioner Albert Hawkins effective September 1, 2009 for a term to expire February 1, 2011. Previously, Mr. Suehs served as the HHSC Deputy Executive Commissioner for Financial Services since 2003.

DSHS is the state agency responsible for the administration of Title V and is one of four HHS agencies under the umbrella of HHSC. The HHSC Executive Commissioner is authorized, with the governor's approval, to employ the DSHS Commissioner and to supervise and direct the activities of the position. Furthermore, HHSC has responsibility for coordinating the development and submission of joint agency strategic plans and a consolidated budget. HHSC is involved in policy development for all HHS agency programs and, as such, reviews all proposed rules and has final authority to adopt rules for each agency.

DSHS Commissioner David L. Lakey, MD, oversees hundreds of health-related prevention, direct care, regulatory, and preparedness programs employing approximately 12,500 employees. Prior to becoming Commissioner, Dr. Lakey served as an Associate Professor of Medicine, Chief of the Division of Clinical Infectious Disease, and Medical Director of the Center for Pulmonary and Infectious Disease Control at the University of Texas Health Center in Tyler. Dr. Lakey is board certified in pediatrics, internal medicine, infectious disease, and pediatric infectious disease.

DSHS performs its duties through staff located at the state headquarters in Austin and throughout eight geographical Health Service Regions (HSRs) statewide; through contracts with autonomous local health departments, community-based organizations, and other groups with a health-related mission; and in-concert with other state agencies and local partners.

Several resources within the DSHS organizational structure assist in program administration. The DSHS Council provides guidance to all programs regarding agency policies and rules. Functions related to administration, infrastructure, and coordination for all DSHS programs are organized under the following areas: Associate Commissioner, Chief Financial Officer, Chief Operating Officer, and Deputy Commissioner.

The Associate Commissioner is Ben Delgado. In this position, Mr. Delgado is directly involved in the day-to-day operations of the agency, addressing both program functions and business

support functions. Mr. Delgado has 30 years of leadership experience, and extensive experience and skills in operational and administrative management. His work portfolio includes public health, child and adult protective services, regulatory, marketing, consumer protection, and workers' compensation.

The Chief Financial Officer is Machelle Pharr who has served in this position since 2002. Ms. Pharr is responsible for administering and directing all DSHS financial activities including accounting, budgeting, grants management, client services contracting, and policy and procedure development.

The Chief Operating Officer is Dee Porter. Ms. Porter oversees administrative, operations, and support services including information technology, contract oversight, health information and vital statistics, general counsel, and operations management.

The Deputy Commissioner is Luanne Southern, MSW, who manages areas that provide coordination and consultation functions across DSHS programs. These functions include internal and external communications, legislative relations, integration and process improvement, project management, and workforce development.

DSHS programs are organized under five divisions: Mental Health and Substance Abuse Services, Regulatory Services, Prevention and Preparedness Services, Regional and Local Health Services, and Family and Community Health Services (FCHS).

Title V administrative functions and a majority of the programs supported by Title V are organized within FCHS. Since July 2004, Evelyn Delgado has been the Assistant Commissioner of FCHS. Ms. Delgado has over 30 years of management experience in the private and public sectors. She previously served as Assistant Deputy Commissioner of Long Term Care Regulatory at the Texas Department of Human Services, protecting the health and safety of elderly and disabled citizens residing in nursing homes and other long term care facilities throughout Texas. Ms Delgado has a business administration degree from Trinity University and is a graduate of the LBJ School of Government Governor's Executive Training program.

FCHS is comprised of 3 sections and 2 offices under Ms. Delgado's leadership: the Community Health Services (CHS) Section, the Specialized Health Services Section (SHS), the Nutrition Services Section, the Office of Title V and Family Health (OTV&FH), and the Office of Program Decision Support (OPDS). FCHS has administrative responsibility for most of the DSHS programs dedicated to women and children's health, including Title V and CYSHCN, Medicaid - EPSDT, WIC, family planning, and breast and cervical cancer screening/diagnosis.

Sam B. Cooper III, MSW, LMSW, was named the State Title V Director effective April 2009. Mr. Cooper also serves as OTV&FH Director overseeing the management and administration of Title V, the Texas Primary Care Office, and the Community Health Worker/Promotora Program. Prior to this position, Mr. Cooper served as the Title V Block Grant Administrator among his many roles in more than 20 years of health and human services experience, primarily in the areas of MCH and CYSHCN. Mr. Cooper received his BA in Psychology and MSW from University of Houston. He is a Licensed Master Social Worker.

The Title V Director and the Block Grant Administrator manage the general administration and reporting functions for the MCH Services Block Grant; consult with Title V-funded programs to ensure that rules, policies, and procedures comply with federal regulations and are delivered in a manner congruent with the intent of Title V; and identify and facilitate opportunities for coordination and integration of resources related to women and children within DSHS and across the HHS System. Collaborative work includes partnering with HHSC on Medicaid and CHIP, as well as with the Office of Program Coordination for Children and Youth to support efforts in coordinating programs and initiatives that serve children and youth.

OPDS works to inform, develop, and implement evidence-based practices leading to an improved understanding and response to the health-related needs of women and children in Texas. Five subject matter experts in the areas of women's and perinatal health, child health, adolescent health, child fatality review, and clinical issues for these populations are funded through Title V to provide consultation to internal and external partners and to plan and implement initiatives that address MCH issues. In addition to subject matter expertise, OPDS provides MCH epidemiology support for program areas including expert statistical analysis, data management and performance measure reporting, geographical/spatial analysis, research design, consultation and evaluation, and literature reviews. OPDS is responsible for the State Systems Development Initiative (SSDI) and the Texas Pregnancy Risk Assessment and Monitoring System (PRAMS).

CHS consists of two Units: the Preventive and Primary Care Unit (PPCU) and the Performance Management Unit (PMU). PPCU is responsible for developing and implementing operational policy and procedures and for providing technical assistance to contractors for the following Title V-funded programs: family planning, prenatal, child health and dental, and dysplasia. In addition, CHS administers breast and cervical cancer screening/diagnosis, primary health care, county indigent health care, and epilepsy services. Clinical oversight for Title V-funded programs is provided by an on-staff board-certified obstetrician/ gynecologist medical consultant and a team of nurses to ensure that clinical protocols and policies utilized by contractors are consistent with nationally-recognized standards, current scientific literature, and Texas statute.

PMU is responsible for developing and managing contracts for all CHS programs, including those that are Title V-funded. These activities include coordinating the contract procurement process, tracking contractor expenditures and performance measures, and ensuring compliance with contract terms and conditions through monitoring performance reports and conducting on-site quality assurance reviews.

Specialized Health Services Section consists of three Units: the Purchased Health Services Unit (PHSU), the Health Screening and Case Management Unit (HSCMU), and the Newborn Screening Unit (NBSU).

The position of Title V CSHCN Director held by Lesa Walker, MD, MPH, is located in PHSU where she also serves as Manager of the Systems Development Group and Medical Director of the CSHCN Services Program (CSHCN SP). Dr. Walker has served in a state and federal leadership role in CSHCN SP for over 24 years.

PHSU develops and administers health care benefits and services through the CSHCN SP, as well as provides medical expertise and consultation to providers of CYSHCN. PHSU also administers a client services program for persons with end stage renal disease and the State organ donation registry and awareness program and oversees eligibility determination, enrollment services, third-party billing, and provider reimbursement for programs within PHSU. CSHCN SP enrolls and reimburses individual health care benefit providers on a fee-for-service basis. In addition to health care benefits, CSHCN SP provides case management services to CYSHCN and their families, including those on the waiting list for health care benefits and also those not eligible for CSHCN SP health care benefits, using both regional DSHS staff and contracted providers. CSHCN SP also provides family supports through both the fee-for-service health care benefits and through contractors.

HSCMU administers federally-mandated preventive health services (EPSDT) to Medicaid eligible clients from birth through 20 years of age through the Texas Health Steps program. Client services include medical and dental care and case management. HSCMU also develops and administers mandated screening programs, including spinal, vision, lead, and hearing as well as case management services all supported by Title V.

NBSU oversees testing, follow-up, and case management resulting from screening all newborns in Texas for 28 inheritable and other disorders. Additionally, NBS provides assistance to

uninsured children identified with an abnormal screen to ensure access to confirmatory testing or treatment. NBS administers Title V-funded genetics services including laboratory testing and diagnosis to help prevent and/or inform low-income families about genetic disorders, follow-up and support services if needed, and genetic counseling.

In addition to central office staff, there are Title V-funded regionally-based staff in each of the eight HSR headquarter offices. DSHS maintains regional offices to provide core public health services in areas of the state with no local health department. Title V-funded positions provide case management, perform population-based activities, and provide front-line technical assistance, training, and quality assurance services to Title V-funded contractors. Consistent with Title V priorities and performance measure activity plans, Title V-funded staff in each HSR develops and implements key initiatives in the area of population-based services. In recent years four areas of focus included access to care, injury prevention, obesity reduction, and teen pregnancy prevention.

An attachment is included in this section.

D. Other MCH Capacity

NUMBER AND LOCATION OF STAFF WORKING IN TITLE V PROGRAMS

Attachment III. D. Other MCH Capacity - Title V Staff details the number and location of staff that are funded by Title V. Compared to FY09, there was a net increase of slightly more than 2 FTEs in FY10 to ensure continued funding of critical positions related to maternal and child health.

CSHCN SP employs staff who are parents or siblings of CYSHCN that participate in the program decision-making process and may offer their insights and feedback to the program on an ongoing basis. A CSHCN SP former staff person is the Texas Family Delegate to the Association of Maternal and Child Health Programs (AMCHP) and was accepted as an AMCHP Family Mentor and Family and Youth Leadership Committee member.

SENIOR LEVEL MANAGEMENT BIOGRAPHIES

Supplemental to the information provided on senior-level management in the previous section, the following biographies detail the qualifications and experience of additional key DSHS management responsible for the provision of maternal and child health-related services in Texas.

Michael Maples, MAHS, LPC, the Assistant Commissioner of the Division of Mental Health and Substance Abuse (MHSA) since August 2008, is responsible for state hospital operations and community mental health and substance abuse contracts. Previously, Mr. Maples served as the Director of MHSA Programs at DSHS, providing leadership, expertise, and oversight for child and adult mental health and substance abuse program policy throughout the State. He has over 15 years of experience in public MHSA service delivery, operations, and development of public behavioral health policy. Mr. Maples received his BA in Psychology from Texas A&M University and his MAHS in Psychology from St. Edwards University. He is a Licensed Professional Counselor and a Licensed Marriage and Family Therapist.

Emilie Becker, MD, has served as Medical Director for Behavioral Health in the DSHS MHSA Services Division since June 2009. She provides support and guidance to the medical directors at the state hospital facilities and serves as a consultant, advising on behavioral health-care issues, to community mental health centers and local providers of substance abuse services. Previously, Dr. Becker was attending physician at Austin State Hospital and acting medical director at the Austin Travis County Mental Health and Mental Retardation and was the child psychiatrist for its Child and Adolescent Emergency Team. Dr. Becker has worked at the Bellevue Hospital in New York, in juvenile corrections settings, and had a private practice. Dr. Becker has training in child

and adolescent psychiatry, as well as forensic psychiatry.

Adolfo M. Valadez, MD, MPH serves as the Assistant Commissioner for Prevention and Preparedness Services. Dr. Valadez is responsible for overseeing infectious and chronic disease control and prevention programs, disaster preparedness and response activities, and laboratory services. Prior to coming to DSHS, Dr. Valadez served as the medical director and health authority for the Austin/Travis County Health and Human Services Department. In the past, Dr. Valadez also served as the medical director of the Martha Eliot Health Center in Jamaica Plain, Massachusetts and as a primary care provider. Dr. Valadez received his medical degree from the University of Texas Medical Branch at Galveston.

Jamie Clark, MSPH, has served as OPDS Director since March 2010. Her DSHS experience includes serving as a research specialist and as the Health Assessment and Reporting Manager in OPDS. Previously, Ms. Clark was the regional epidemiologist for the Utah Department of Health and was a senior research analyst for the Idaho Department of Health and Welfare. Ms. Clark has a Bachelor of Science in Behavioral Science and Health and a Master of Science degree in Public Health from the University of Utah.

L. Jann Melton-Kissel, RN, MBA, is Director for the Specialized Health Services (SHS) Section, since September 2004. SHS is comprised of three units: Newborn Screening (NBSU), Purchased Health Services Unit (PHSU), and Health Screening and Case Management Unit (HSCMU). Ms. Melton-Kissel is responsible for directing, planning, implementing, and evaluating health services for children. The SHS Section continues its focus on increasing service integration, and assuring that systems are accessible for clients, community members, and providers. Ms. Melton-Kissel began employment with the agency in 1986 and has held multiple positions at various levels of responsibility, gaining experience in budget and management.

Linda M. Altenhoff, DDS, is the State Dental Director and Manager of the Oral Health Branch in HSCMU since November 2004. Dr. Altenhoff oversees the oral health aspects of the Texas Health Steps (EPSDT) Program, the Public Health Dental Program, and the Sealant and Oral Health Promotion Programs. She has previously served as Director of Texas Health Steps, Medicaid Medical Transportation, Oral Health, and was a Regional Dental Director at DSHS. Dr. Altenhoff has experience in private practice and as a consultant. She is active in state and national associations including being a board member of the Medicaid and SCHIP Dental Association and was Director of the Association of State and Territorial Dental Directors. Dr. Altenhoff received her Doctor of Dental Surgery degree from the University of Texas Health Science Center at San Antonio.

Debra Freedenberg, MD, PhD, is the Genetics Physician Consultant for the Newborn Screening Genetics Branch since January 2009. She has worked in Genetics for over 33 years, most recently as an Associate Professor at Vanderbilt University Medical Center in Nashville, Tennessee. Dr. Freedenberg holds degrees in Biology, Biomedical Sciences, and Medicine; is a member of the American Medical Association, Society of Inherited Metabolic Disease, American Society of Human Genetics, and Fellow of the American Academy of Pediatrics; and is a Founding Fellow of the American College of Medical Genetics. She is a Diplomat of the American Board of Pediatrics and the American Board of Medical Genetics. Dr. Freedenberg authored and co-authored more than 22 published articles in various academic journals.

Carol Pavlica Labaj, RN, BSN, Manager of PHSU since March 2007, is responsible for 4 programs: CSHCN SP, Kidney Health Care, Hemophilia Assistance Program, and the Glenda Dawson Donate Life Texas-Registry. Responsibilities include interpreting and implementing federal, state, and department policies; developing and implementing program strategic planning; coordinating client eligibility and service benefits administration; developing and maintaining mechanisms to ensure that administrative and client service expenditures remain within budgetary limitations; and meeting state and federal performance measures. Mrs. Labaj has worked in the public health field since 1972.

Lesa Walker, MD, MPH, is the Title V Children with Special Health Care Needs (CSHCN) Director and Medical Director of the CSHCN Services Program (CSHCN SP) and Manager of the Systems Development Group, PHSU. She oversees the planning and implementation of Title V CYSHCN activities, initiatives, community-based contractor services, and systems development. She manages the Glenda Dawson Donate Life-Texas Registry. Dr. Walker has served in a state and federal leadership role in CSHCN SP for over 24 years. She authored many program policies, reports, articles, and rules; and contributed to Healthy People 2010 relating to people with disabilities. She is board certified in General Preventive Medicine/Public Health.

Dale A. Ellison, MD, is the Policy and Program Development Branch Manager and assistant medical director for PHSU effective May 2008. Dr. Ellison is board certified in anatomic and clinical pathology with sub-specialty boards in pediatric pathology. She has worked in the field of pediatric pathology for more than 15 years, a career that includes positions as director of: microbiology, surgical pathology, and hematology coagulation lab. She was the acting medical director of the laboratory at Dell Children's Medical Center prior to coming to DSHS.

Patrick Gillies, MPA, has served as the Director of the Community Health Services (CHS) since February 2008. CHS is comprised of two units: Preventive and Primary Care and Performance Management. These units are involved in the implementation and quality assurance of a number of direct services funded by Title V. Mr. Gillies has worked for the State of Texas for 12 years providing program and contractual management and developing health purchasing systems. Mr. Gillies received his Master of Public Administration degree from Texas Tech University.

Janet D. Lawson, MD, FACOG, is the CHS Medical Consultant since November 2009. She provides medical consultation for the programs within CHS including breast and cervical cancer, prenatal, child health, primary health care, and family planning services. Since 1996, she has served in a variety of positions at DSHS, including Director of the Division of Women's Health; Medical Consultant for the Bureau of Clinical and Nutrition Services; leadership in the Bureau of Community Oriented Public Health and the Bureau of HIV/STD Prevention; Medical Director for the South Texas Health Care System; and was Assistant Commissioner for the Division of Regional and Local Health Services. Dr. Lawson is board certified by the American Board of Obstetrics and Gynecology.

Mike Montgomery is the Director of the Nutrition Services Section in FCHS since 2001. He provides overall direction, policy development, and policy enforcement for WIC and the Farmers' Market Nutrition Program. Previously, he led the Texas WIC project development team for the Electronic Benefits Transfer (EBT) project and was Chief of the Bureau of Nutrition Services before leading the Children's Health Bureau. Mr. Montgomery has more than 30 years experience with WIC, having served across the spectrum of management and administration in positions at the federal, state, and local level including 22 years with the USDA's Food and Nutrition Service. Mr. Montgomery has a Bachelor of Science degree from the State University of New York with majors in Sociology and Psychology.

TENURE OF STATE MCH WORKFORCE

DSHS employees have an average age of 44 years; approximately 63% of the DSHS workforce is 41 years or older. Approximately 45% of DSHS employees have 10 or more years of service. About 11% of the DSHS workforce is currently eligible to retire from state employment. Over the next 5 years, over one-fourth of the agency workforce will reach retirement eligibility. The turnover rate in FY09 at DSHS was higher than the state average. DSHS anticipates there will be a need for additional health-related services as the population of the state increases and expects increased competition for qualified job applicants.

Based on these trends and current employment conditions, DSHS anticipates continued difficulty recruiting and retaining qualified and experienced employees. Workforce challenges include:

retirement of numerous management and professional staff in the next 5 to 10 years; increased workloads; severe nursing staff shortages; limited funding for training and travel; increased need for bilingual staff; limited or lack of career ladders; and non-competitive starting salaries. DSHS has difficulty filling vacant positions for registered nurses, human services specialists (public health case managers), epidemiologists, physicians, dentists, laboratory technicians, and medical technologists.

PROJECTED CHANGES TO WORKFORCE IN THE COMING YEAR

Dr. Lesa Walker, the Title V CSHCN Director for the past 24 years, has announced her retirement from DSHS effective August 31, 2010. Dr. Walker's retirement represents a significant change in the Texas MCH workforce as her passion and commitment for the families of Texas that she has touched through her work at DSHS are immeasurable.

State budget reductions that may impact Title V programs are possible. In January 2010, due to the uncertainty of Texas' economic future and the national recession, Governor Rick Perry, Lieutenant Governor David Dewhurst, and Speaker of the House Joe Straus requested each agency to submit a plan to identify savings of 5% of state general revenue and general revenue dedicated appropriations for the FY10-11 biennium. This request was followed by a Health and Human Services (HHS) Executive Memorandum from HHSC Executive Commissioner Thomas Suehs that implemented a freeze on hiring, merit awards, and overtime for all HHS agencies.

At the end of May 2010, DSHS received instructions for the FY12-13 Legislative Appropriations Request (LAR), the process by which DSHS requests funding from the legislature for the next two years. In these instructions, each state agency was asked to submit a plan for reducing general revenue budgets by an additional 10%. This amount is in addition to the general revenue reductions for the FY10-11 biennium. The outcome will not be final until May 2011 when the 82nd Texas Legislative Session concludes.

An attachment is included in this section.

E. State Agency Coordination

Given the large size of Texas, geographically and demographically, there are numerous efforts addressing MCH needs throughout various state and local government and private/non-profit organizations. Since state legislation and/or funding grantees charge multiple agencies at both the state and local levels with responsibility for various MCH activities, DSHS recognizes the importance of partnership building and collaboration as critical components in addressing MCH needs if these efforts are to be successful. In addition to staff that work to administer the Title V Block Grant, subject matter experts funded by Title V in the areas of women‘s and perinatal health, child health, adolescent health, child fatality, CYSHCN, and clinical MCH issues are charged with working collaboratively across programs and agencies throughout the state.

ORGANIZATIONAL RELATIONSHIPS AMONG HHS SYSTEM

Title V collaborates most closely with HHSC and agencies under the auspices of HHSC, including the Department of Family and Protective Services (DFPS), Department of Aging and Disability Services (DADS), and Department of Assistive and Rehabilitative Services (DARS), collectively known as the Health and Human Services (HHS) System.

HHSC oversees the operations and policies of the entire HHS System, and directly operates the Medicaid program, the Children's Health Insurance Program (CHIP), and several family support programs. HHSC also operates a consolidated eligibility determination function for several major programs and provides consolidated, coordinated administrative support for all HHS System agencies.

For example, in Texas, a woman is eligible for Medicaid if she meets the requirements for TANF, or she is pregnant and is at or below 185% FPL. Although CHIP serves children age 0-19 years from low-income families, coverage was expanded in 2007 to provide prenatal care to pregnant women with a family income up to 200% FPL who are ineligible for Medicaid. By virtue of serving similar populations with comparable services, Medicaid, CHIP, and Title V must partner closely to meet the needs of women and children in the state without duplication of efforts. Through an integrated screening process, individuals are referred to the appropriate program based on eligibility criteria. Moreover, all Title V contracted fee-for-service providers are required to assist individuals in the eligibility screening process and to be Medicaid providers to help ensure the client a seamless transition from eligibility screening to receiving services.

Continuing with the example of prenatal services, HHSC and DSHS have worked to minimize delays in access to care, ultimately agreeing that Title V-funded prenatal services contractors provide two prenatal visits during the time an application for CHIP Perinatal benefits is in process. Furthermore, DSHS encourages all contracted providers to become CHIP Perinatal providers to once again ensure the client a seamless transition to services. Finally, Title V does not participate in rate setting activities, but instead uses Medicaid rates as a guide to reimbursing fee-for-service contractors.

Specific to CYSHCN, Title V staff participate on the Benefits Management Workgroup, a policy development and coordination effort led by HHSC to ensure collaboration between Medicaid and CSHCN SP policy implementation. CSHCN SP provides "wrap around" services (e.g. travel reimbursement, case management, family support services) to CHIP and Medicaid clients when needed.

With the potential for overlap of Medicaid, CHIP, and DSHS programs, an executive team has been established through the DSHS Office of Priority Initiatives Coordination (OPIC). The purpose of OPIC is to provide support to the DSHS Commissioner‘s Office to ensure that the vast array of legislative mandates, exceptional item funding, and agency priority projects are identified, resourced, and managed in a manner that meets DSHS‘ obligations to partners, clients, stakeholders, and oversight agencies. Most recently, agency leadership established the DSHS Medicaid Executive Management Team to ensure proactive cross-agency communication, collaboration, and risk/issue management related to the following three areas: Medicaid Policy, Texas Health Steps (EPSDT), and other Medicaid-related efforts.

Because multiple agencies have programs and activities related to or responsibilities for parts of Medicaid and CHIP, DSHS, DARS, DFPS, and DADS have established a system of communication that supports collaborative efforts in planning and the administration of these and other health and social service programs. An electronic project alert system has been created to ensure that as programmatic changes occur, all agencies are provided basic information that can be used to determine whether more involvement through communication on project status is sufficient, or whether formal participation on work groups is needed. Efforts are led by staff in HHSC, but each of the four HHS agencies has ongoing communication mechanisms in place to promote effective coordination.

Opportunities which support collaborative efforts for interagency collaboration include:

The Texas CHIP Coalition -- The Texas CHIP Coalition was formed in 1988 to bring together state and local organizations to support adequate state funding and program improvements for CHIP and Children‘s Medicaid. The coalition engages in public education and advocacy, working closely with state agencies and the Texas legislature on behalf of children and their families.

The Task Force for Children with Special Needs -- The creation of the Task Force for Children with Special Needs by the 81st Texas Legislature (2009) provides a focused opportunity for collaboration regarding services for CYSHCN and their families. The Task Force was established with subcommittees to address key issues in the areas of health, mental health, education,

transitioning youth, juvenile justice, long-term care, and early childhood intervention and crisis prevention. The DSHS Assistant Commissioner for FCHS serves as the chair of the Health Subcommittee and CSHCN SP staff members are actively involved in providing information and expertise. Due to the high-level visibility, leadership, charge, and accountability of the Task Force, there will be a tremendous opportunity to coordinate, improve, and advance services for CYSHCN in Texas.

The Council on Children and Families -- The DSHS Deputy Commissioner of Health represents DSHS on the Council on Children and Families. The Council was established by the 81st Texas Legislature (2009) to help improve the coordination of state services for children by coordinating the state's health, education, and human services systems to ensure that children and families have access to needed services; improving coordination and efficiency in state agencies, advisory councils on issues affecting children, and local levels of service; prioritizing and mobilizing resources for children; and facilitating an integrated approach to providing services for children and youth. The membership on the Council is composed of executive leadership from HHS agencies, juvenile justice agencies, Texas Education Agency (TEA), Texas Workforce Commission, and representatives from the public including two public representatives who are parents of children who have received services from an agency represented on the Council, and two representatives who are young adults or adolescents who have received services from an agency represented on the Council.

The Interagency Coordinating Council (ICC) for Building Healthy Families -- This Council was established by the 79th Texas Legislature (2005) and is charged with facilitating communication and collaboration concerning policies for the prevention of and early intervention in child abuse and neglect among state agencies whose programs and services promote and foster healthy families. State agencies represented on the Council include HHSC, DSHS, DFPS, DADS, DARS, Texas Youth Commission, TEA, Texas Workforce Commission, Office of the Attorney General, Texas Juvenile Probation Commission, and Texas Department of Housing and Community Affairs. DSHS is represented on the Council by the State Title V Director. In 2007, the 80th Texas Legislature (2007) provided new direction; it re-authorized the Council, added DARS as a member, and directed the Council to continue its collaborative work. New requirements included an evaluation of state-funded child maltreatment prevention programs and services and the development of a DFPS Strategic Plan for Child Abuse and Neglect Prevention Services undertaken in consultation with the Council.

Office of Program Coordination for Children and Youth (OPCCY) -- DSHS Title V staff work closely with HHSC's OPCCY. OPCCY assists in coordinating programs and initiatives that serve children and youth across the HHS System. In addition, it also oversees the operation of various children's programs and initiatives from the following areas: Community Resource Coordinating Groups (CRCGs), Texas Integrated Funding Initiative (TIFI), Children's Policy Council, Raising Texas, and Healthy Child Care Texas (HCCT).

CRCGs are local interagency groups comprised of public and private agency representatives who develop service plans for individuals and families whose needs often highlight gaps in the regular service delivery system and require more intensive service coordination. The 70th Texas Legislature (1987) created CRCGs and directed state agencies serving children to develop a community-based approach to better coordinate services for children and youth who have multi-agency needs and require interagency coordination. CRCGs are organized and established on a county-by-county basis with members from public and private sector agencies and organizations and include parents, consumers, or caregivers as members. Regional Title V-funded social workers serve on all local CRCGs and central office DSHS staff are represented on the state advisory committee.

DSHS staff serve as representatives to TIFI which supports flexible funding collaboration between governmental and private sector agencies to serve children and youth with complex mental health needs. TIFI assists in developing systems of care that focus on individualized services that move

beyond traditional child-centered mental health services to encompass more comprehensive supports for the entire family.

CSHCN SP staff represents DSHS on the Children's Policy Council. The Children's Policy Council assists HHS agencies in developing, implementing, and administering family support policies and related long-term care and health programs for children. Membership is composed primarily of family members of consumers and is supported by state agencies such as HHSC, DSHS, and DFPS. The Council provides recommendations to the state legislature on issues such as: access of a child or a child's family to effective case management services; transition needs of children who reach an age at which they are no longer eligible for services; collaboration and coordination of children's services and the funding of those services between state agencies; and effective permanency planning for children who reside in institutions or who are at risk of placement in an institution.

Raising Texas is a statewide, collaborative effort to strengthen Texas' system of services for young children and families so that all children enter school healthy and ready to learn. Through the collaborative partnership of 9 state agencies, 16 community based agencies and 60 key stakeholders, a state plan has been developed to improve the current system of services for all children age birth to 6. The Raising Texas strategic plan promotes evidence-based practice and increases coordination among health, behavioral health, and education services. DSHS MCH and CSHCN SP staff serve on the Raising Texas Initiative supporting the Medical Home and Parent Education and Family Support sub-committees.

HCCT brings together health care professionals, early care and education professionals, child care providers, and families to improve the health and safety of children in child care. The current HCCT initiative has two approaches to training consultants. It trains qualified individuals to be Child Care Health Consultants (e.g., RNs, child development specialists, early childhood education specialists) or Medical Consultants (e.g., physicians, residents, physician assistants, nurse practitioner). The goals for HCCT are to maximize the health, safety, well-being, and developmental potential of all children so that each child experiences quality child care within a nurturing environment, and to help increase children‘s access to preventive health services, including a medical home.

Medical Home Work Group -- Coordinated by CSHCN SP staff, the Medical Home Workgroup strives to enhance the development of and access to medical homes in Texas. Workgroup membership includes family members of CYSHCN, representatives from community organizations, state agencies and family advocacy organizations, community physicians and other health care providers, insurers, and other partners. The workgroup has developed a strategic plan to achieve the goal that all children in Texas, including CYSHCN, will receive their health care in a medical home. A key part of the strategic plan is to increase the number of health care practitioners who provide a medical home.

RELATIONSHIP WITH STATE AND LOCAL PUBLIC HEALTH DEPARTMENTS, FQHCS, AND PRIMARY CARE ASSOCIATIONS

Title V funds the provision of direct and enabling health care services for women seeking family planning, dysplasia, and prenatal care; for infants, children, and adolescents needing well-child check-ups and dental care; children and youth with special health care needs and their families seeking coordinated health care services tailored to their individual needs; for families interested in genetic screening and counseling services, and for school-based health centers. The majority of these services are provided through contracts with local providers including city/county health departments, hospital districts, school districts, Federally Qualified Health Centers (FQHCs), non-profit agencies, and individual providers.

In addition to direct and enabling services, Title V funds population-based and infrastructure building services carried out by local entities. For example, DSHS implemented the Texas

Healthy Adolescent Initiative (THAI) to improve the overall health and well-being of Texas adolescents, age 10-18 years. THAI provides funding for Local Community Leadership Groups to conduct a needs assessment and develop a strategic plan for their community to address adolescent health through a comprehensive youth development approach. Six communities in Texas were selected to participate in this initiative beginning September 2009 in Longview, San Antonio, Fort Worth/Dallas, Austin, Houston, and Lubbock. Additionally, Title V staff coordinates school health programming with TEA and other DSHS programs with the goal that students receive a program of physical and health education, appropriate health services, and a nurturing environment. Regional School Health Specialists are supported through Title V funding and are stationed in each of the 20 TEA Regional Education Service Centers.

Title V-funded staff have collaborative relationships with non-profit and professional organizations with an interest in maternal and child health, including among others: the Texas Medical Association, Texas Academy of Family Physicians, Texas Nurses Association, Texas Association of Obstetricians and Gynecologists, Texas Dental Association, Texas Association of Local Health Officials, Texas Association of Community Health Centers, Texas Association of Local WIC Directors, Texas Mental Health America, Children's Policy Council, Promoting Independence Advisory Committee, Texas Parent to Parent, March of Dimes, Texas Council on Developmental Disabilities, Early Childhood Intervention Advisory Council, Texas Pediatric Society, Traumatic Brain Injury Advisory Council, and the Leadership and Education in Adolescent Health (LEAH) Advisory Committee. Through these relationships, information, knowledge, and resources are shared and the entities work together to further joint projects and common goals. Many of these groups issue formal reports and submit recommendations to the Texas Legislature.

RELATIONSHIP TO PROFESSIONAL EDUCATION PROGRAMS AND UNIVERSITIES

DSHS in collaboration with HRSA Region VI Title V Directors (Texas, Louisiana, New Mexico, Oklahoma, and Arkansas) anticipates enhanced training opportunities and technical assistance from the University of Texas and Baylor Medical Center Multimodal MCH Training Program that will help build maternal and child health staff expertise and MCH public health infrastructure. Both organizations have strong ties to Title V leaders and know the diverse needs of the MCH populations in each state.

DSHS MCH and CSHCN SP staff partner with Baylor College of Medicine, the LEAH grantee for Texas, on a variety of initiatives. LEAH works to improve the health and well-being of adolescents through education, research, program and service model development, evaluation, and dissemination of best practices. CSHCN SP staff participates on the planning committee for and attends the LEAH Program‘s annual Chronic Illness and Disability Conference. Title V contracts with LEAH to provide: scholarships for family members of CYSHCN to attend the conference; one-month rotations of 12 internal medicine residents through a transition clinic for older teens and young adults with chronic diseases and disabilities; and implementation, and evaluation of an innovative electronic health record adolescent-to-adult health care transition template.

COORDINATION WITH OTHER INITIATIVES

EPSDT -- DSHS administers preventive health services to Medicaid EPSDT eligible clients from birth through 20 years of age through the Texas Health Steps program. DSHS leadership uses the Medicaid Executive Management Team to ensure cross-agency communication, collaboration, and risk/issue management related to Medicaid Policy and Texas Health Steps. Title V staff are actively involved with HHSC in actions relating to the lawsuit concerning preventive services in Children's Medicaid (the Frew v. Suehs lawsuit) and provide support for the strategic initiatives that have been developed to improve direct care for children with Texas Health Steps/Medicaid coverage. Title V staff also partner with Texas Health Steps to develop on-line training modules free to all types of providers on a wide variety of child/adolescent health and safety issues and other professional development topics.

WIC -- Title V staff continue to collaborate with the federal Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), administered by DSHS, on breastfeeding promotion and other issues that enhance the health of their shared populations, such as tobacco cessation and promotion of physical activity and nutrition.

SSA -- CSHCN SP case management staff and contractors assist families in completing applications and obtaining disability determinations as needed in order that CYSHCN may access appropriate Social Security Administration (SSA) Supplemental Security Income (SSI) and other benefits. Children and youth eligible to receive SSI benefits in Texas receive health care benefits through Medicaid. CSHCN SP provides outreach to SSI eligible clients to determine the need for case management services. Additionally, it provides back-up, gap-filling health benefits coverage if a child receiving SSI loses Medicaid due to an extra SSI payment in a month. Vocational rehabilitation (VR) services for CYSHCN typically begin during the high school years as a complement to education transition services. Beginning at age 16, all children receiving special education services may receive transition vocational rehabilitation services through DARS. DARS has 100 Transition VR counselors co-located in schools all across Texas to facilitate providing these services. CSHCN SP staff collaborate on both state and local levels with DARS staff and educators throughout Texas to support transition of CYSHCN into post-secondary education, employment, and independent living.

Healthy Start -- Title V staff work collaboratively with the Texas Healthy Start Alliance to strengthen the efforts targeting the high risk populations that Healthy Start serves. The Healthy Start sites are working on a variety of population-based activities, including breastfeeding, immunization compliance, diabetes and risk factors of overweight/obesity, folic acid promotion, sexually transmitted infection prevention, early prenatal care social marketing campaigns, and car seat safety. Texas has six Healthy Start sites that are organized into a single Texas Healthy Start Alliance. The six sites in Texas are in Brownsville, Houston, Fort Worth, Dallas, Laredo, and San Antonio.

Rape Prevention Education -- Title V staff work on the CDC Rape Prevention and Education (RPE) grant. DSHS contracts with the Texas Office of the Attorney General‘s Sexual Assault Prevention and Crisis Services Program to implement this grant. These activities support the primary prevention of sexual assault and/or violence. The following activities are used to achieve the goals of the project: educational seminars, training programs for professionals, preparation of information material, and education and training programs for students and campus personnel designed to reduce the incidence of sexual assault. Currently, the RPE Planning Team is in the process of implementing the CDC-approved State Plan for the Primary Prevention of Sexual Violence in Texas. This includes exploring ways to expand the prevention efforts beyond education and training to policy and environmental change.

Big 5 State Prematurity Collaborative -- Title V staff partner with the March of Dimes on the Big 5 State Prematurity Collaborative and with the Texas' Big 5 Quality Improvement Committee. The March of Dimes Big 5 State Prematurity Collaborative is exploring data-driven perinatal quality improvement through the development and adoption of evidence-based interventions and the data systems and tools required to track changes in specific perinatal issues and indicators in the nation's five biggest states (California, Florida, Illinois, New York, and Texas).

F. Health Systems Capacity Indicators

Introduction

The Health Status Capacity Indicators (HSCIs) for Texas identify areas of great improvement and areas in need of attention. The rate of children hospitalized for asthma ranged from a low of 23.7 per 10,000 children in 2009 to a high of 28.4 per 10,000 children in 2006. This decline represents both a cost savings to the Texas health care systems and an improvement in the area of preventive health. Since 2006, 100.0% of Medicaid enrolled infants received at least one initial

periodic screen. In addition to these successes, the HSCIs identified areas for improvement in Texas. Indicators for prenatal care, low birth weight, and infant mortality all lag behind 2010 objectives. There is also a significant disparity between Medicaid and non-Medicaid populations. To address these indicators, Texas continues to explore outreach methods for enrolling participants in Medicaid and CHIP including activities of Title V-funded contractors and regional DSHS staff. In addition to expanded coverage, Texas has conducted and shared the results of a Perinatal Periods of Risk Analysis, has funded several projects aimed at addressing disparities in the adequacy of prenatal care, and has analyzed and promulgated results of Texas PRAMS. Texas will continue to use data to inform initiatives and interventions that will reduce the disparities in these indicators and contribute to achieving internal state targets and national Healthy People 2010 and future Healthy People 2020 objectives.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	25.9	28.4	27.7	24.1	23.7
Numerator	4745	5349	5284	4642	4615
Denominator	1835331	1881855	1906500	1927981	1951170
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data Source: Texas Hospital Inpatient Discharge Public Use Data File.

The numerator estimates for 2009 are based on a linear projection using data from 2000 through 2008. The data is based on hospitalizations. Therefore, one person may account for multiple hospitalizations. The reported data may underestimate the true rate of hospitalization for asthma because Texas hospitals (located in a county with a population less than 35,000) are exempt from the reporting to the Texas Health Care Information Council (THCIC). Denominator data are provided by the Office of the State Demographer.

Notes - 2008
Data Source: Texas Hospital Inpatient Discharge Public Use Data File.

The data is based on hospitalizations. Therefore, one person may account for multiple hospitalizations. The reported data may underestimate the true rate of hospitalizations for asthma because some Texas hospitals (located in a county with a population less than 35,000) are exempt from the reporting to the THCIC. Denominator data are provided by the Office of the State Demographer.

Notes - 2007
Data Sources: Hospitalizations- Texas Hospital Inpatient Discharge Public Use Data File.Texas Health Care Information Council (THCIC), Austin, TX. 2006. Texas Population for calculation of rates-Texas State Data Center, Texas Population Estimates and Projections Programs, Texas A&M University, September 2006. 2007 is a trend based on 4 years of data.

The data is based on hospitalizations, not people in the numerator. These numbers may be underestimated of the true rate of hospitalizations for asthma because some Texas hospitals (located in a county with a population less than 35,000) are exempt from the reporting to the THCIC.

Narrative:
The Healthy People 2010 objective is to reduce hospitalization for asthma in children 0 to 5 years of age to 25 per 10,000 or less. In 2008, the rate of hospitalizations per 100,000 declined to 24.1 per 100,000. Projections for 2009 indicate that the rate of asthma hospitalizations in Texas will remain below the 2010 objective.

The Texas environment is challenging for persons with asthma. Texas is home to a diverse mix of air pollutants. The Gulf Coast region is home to one of the largest petrochemical complexes in the world. Many Texas cities have grown dramatically over the past 20 years increasing the numbers of automobiles and trucks on Texas roads. These factors coupled with the high number of days with sunshine, contribute to air pollution in most of our cities. The documented declines from the year 2000 can be attributed to the Asthma Coalition of Texas, in which the DSHS is an active participant. The work of the Asthma Coalition of Texas focuses on six issues :

1) Infrastructure and collaborations: building a network of asthma stakeholders and partners to carry out asthma activities statewide, regionally and at the community level and development of local community based coalitions to address asthma.

2) Surveillance: to maintain, improve and expand asthma surveillance in Texas, including identifying health disparities and under-diagnosed populations.

3) Clinical management of asthma: increase the use of evidence-based and best practice guidelines for the diagnoses, treatment and management of asthma by all health care professionals to optimize health care delivery to all individuals.

4) Education: expansion and improvement of quality asthma education to ensure consistency with the National Asthma Education and Prevention Program Guidelines, development of culturally competent and health literate resources regarding asthma, and development of public awareness campaign to increase understanding of asthma.

5) Community and public health policy: development of policies and programs to target asthma in the following areas: asthma in schools, work related asthma, health system change, environment, and public policy.

6) Health disparities and access to care: addressing and striving to eliminate the unequal burden of asthma among racial and ethnic minorities and medically underserved populations through data collection, development of culturally competent resources and target interventions based on needs identified through data collection.

In addition to the work of the Asthma Coalition of Texas, research literature has demonstrated that appropriate management by primary care providers can help avoid asthma hospitalizations. Title V will continue to work toward a continued decline in the number of children hospitalized for asthma in Texas.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	96.4	100.0	100.0	100.0	100.0
Numerator	244236	258808	259222	240809	238896
Denominator	253418	258808	259222	240911	238927
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
CMS-416 FFY2009

Notes - 2008
Texas CMS-416 FFY 2007 - 2008

Notes - 2007
100% reported on CMS-416. Numerator and denominator had slight differences due to data reporting system.

Source:
Texas CMS-416 FFY 2006 - 2007

Narrative:
In 2005, 96.4 percent of Medicaid enrollees aged less than one year received at least one initial periodic screen. In 2006-2009, 100.0 percent of Medicaid enrollees aged less than one year received at least one initial periodic screen. Preventive care that starts early is essential to the lifelong health of an individual and this capacity indicator bodes well for the health of Texas' children. The improvement in this measure may be attributable to the enhanced efforts of the Texas version of the EPSDT program, Texas Health Steps, to inform caretakers of newly certified individuals on the value of preventive services. This outreach stresses the value of a medical home, the importance of preventive care, and active assistance in scheduling medical, dental and transportation services.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	41.7	38.5	42.1	70.6	71.7
Numerator	1600	1243	944	45208	64065
Denominator	3837	3226	2243	64026	89369
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

Source: Texas Health and Human Services Commission (HHSC).

Notes - 2008
Source: Texas Health and Human Services Commission (HHSC).

Notes - 2007
Prior to 2005, denominator data included all Texas SCHIP recipients.

Source:
Texas Health and Human Services Commission (HHSC).

Narrative:
Although the percentage of children who are less than 1 year of age and on SCHIP who receive at least one periodic screen was similar for 2008 and 2009, the actual number of infants increased substantially during that time period. It took approximately a year for an increase in the CHIP Perinatal program to occur. These years differed dramatically from previous years due to changes in the enrollment requirements. The 78th Texas Legislature in 2003 made changes to the eligibility enrollment requirements. These changes include: 1) decreasing the continuous coverage period from 12 months to six months; 2) increasing premiums for families above 100% FPL and cost-sharing for families below 185% FPL; 3) elimination of income deductions for items such as child care costs; and 4) implementing a 90-day waiting period for coverage. In addition to changes at the state level, new federal regulations require enrollees in CHIP to provide affirmation of their identity and their income. While these regulations may aid in the identification of families who are no longer eligible for services, they may erect a barrier to enrollment.

In 2007, the 80th Texas Legislature revised the CHIP eligibility and enrollment requirements to return the coverage period to 12 months, reinstate income deductions for dependent care, and eliminate the 90-day waiting period. The changes took effect on 9/1/07. These changes led to an increase in the proportion of SCHIP enrollees less than one year of age who received at least one periodic screening. The increase between 2006 and 2007 surpassed the decline between 2005 and 2006. The continuation of the CHIP Perinatal Program, which provides prenatal services to women who are ineligible for Medicaid to improve the health of the infant, increased access to and participation of services that benefit the eligible infants.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	62.6	62.0	64.0	65.9	67.8
Numerator	240620	242388	258337	270350	282921
Denominator	384292	390702	403690	410542	417394
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average					

cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
All natality data reported for 2007, 2008, and 2009 are estimates. In 2005, Texas implemented the US Certificate of Live Birth, 2003. This change had a significant impact on measures of prenatal care utilization and precluded the use of a linear projection. Average annual increase was calculated (4.6%) and applied to the numerators in 2007, 2008, and 2009.

Notes - 2008
All natality data reported for 2007, 2008, and 2009 are estimates. In 2005, Texas implemented the US Certificate of Live Birth, 2003. This change had a significant impact on measures of prenatal care utilization and precluded the use of a linear projection. Average annual increase was calculated (4.6%) and applied to the numerators in 2007, 2008, and 2009.

Notes - 2007
All natality data reported for 2007, 2008, and 2009 are estimates. In 2005, Texas implemented the US Certificate of Live Birth, 2003. This change had a significant impact on measures of prenatal care utilization and precluded the use of a linear projection. Average annual increase was calculated (4.6%) and applied to the numerators in 2007, 2008, and 2009.

Narrative:
Among projected figures for resident births in 2009 for women ages 15-44, the percentage with adequate or better prenatal care was 67.8%, which was an increase from 2005. Title V funds contractors to provide accessible, high quality, culturally competent prenatal care across Texas. However, despite this support, the supply of health care providers to fully serve the at-risk population is less than the demand. Several Texas counties have no health care providers that offer these services. In other cases, providers may not be fully cognizant of the needs of the population, especially as the demographics of Texas are changing due to an influx of new populations with diverse needs. Women's health care systems may not be working in an integrated, comprehensive manner, so appropriate and timely referrals are not made or necessary follow up does not occur. DSHS will engage medical residency programs in discussions regarding the National Health Service Corps and loan repayment programs, and continue to use the Conrad 30 J-1 Visa Waiver Program to help rural and underserved areas recruit foreign physicians. Title V continues to work to identify solutions and strategies with stakeholders to aid early enrollment into prenatal care.

This continues to be a challenging indicator for Texas at this time. Currently, the most recent final natality file available in Texas is 2006. In 2005, Texas implemented the new 2003 US Certificate of Live Birth, which changed the manner in which prenatal care data were collected. While projections for 2007, 2008, and 2009 are provided, these projections cannot appropriately account for the impact of the implementation of the new birth certificate based on only two years of data. The implementation of the CHIP Perinatal Program also occurred after 2005. Therefore, current data cannot measure the impact of this program and, as it is a new program, it cannot be adequately addressed through projections. As the prenatal care landscape continues to change in Texas and more recent data become available, it will be important to assess the impact that these changes had on this indicator to determine future policy and programmatic directions.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**

Annual Indicator	62.9	64.5	65.6	60.0	64.5
Numerator	1317797	1370299	1405344	1311475	1484899
Denominator	2095657	2123317	2142033	2186066	2303703
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Source: Texas CMS-416 FFY 2009.

Notes - 2008
Source: Texas CMS-416 FFY 2008.

Notes - 2007
Source:
Source: Texas CMS-416 FFY 2007.

Narrative:
Between 2005 and 2009, the percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program increased from 62.9% (2005) to 64.5% (2009), an increase of 2.5%. The percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program has exceeded 60% since 2003. The Title V program monitors this figure annually as part of the grant development process. A contributor to the increase is the practice in Title V-funded contractors throughout the state of screening and referring children who are potentially eligible for Medicaid and CHIP. With the increased outreach among the patient population and training offerings to the Medicaid provider population, continued increases are expected in this measure. Statewide efforts continue to perform outreach and informing activities for clients; to provide education and training about Texas Health Steps; and to use other innovative efforts to increase the number of services provided. There are currently 40 modules available online for providers regarding Texas Health Steps education and training. The award-winning online program offers free CE Courses to enhance providers' ability to provide preventive health, mental health, oral health and case management services to Medicaid eligible children in Texas. An example of the innovative efforts include the Children's Medicaid Loan Repayment Program for physicians and dentists who provide care to children on Medicaid, as well as other initiatives that focus on improving access to medical and dental benefits.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	56.3	55.2	58.1	61.0	62.6
Numerator	301346	308987	330435	357067	394286
Denominator	535079	559406	569106	585453	629784
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last					

year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Source: Texas CMS-416 FFY 2009.

Notes - 2008
Source: Texas CMS-416 FFY 2007 - 2008.

Notes - 2007
Source: Texas CMS-416 FFY 2007.

Narrative:
Between 2005 and 2009, the percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year increased from 56.3% (2005) to 62.6% (2009), an increase of 11.2%. The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year has exceeded 55% since 2003. This improvement is attributable to several factors, including but not limited to, enhanced outreach and information, and scheduling and transportation assistance efforts provided through the Texas version of the EPSDT program, Texas Health Steps. These outreach efforts have focused on the fact that early access to preventive dental services can decrease the level of dental disease experienced by this population group and have generated an increasing number of inquiries from clients and their caregivers about oral health. Allowances have been made to increase the reimbursement rate for dental providers. Additional participation increases are expected in coming years as Medicaid dental reimbursement rates may increase. Two dental strategic initiatives were implemented in 2008. The goal of the First Dental Home (FDH) initiative, implemented in March 2008, is to promote the concept of establishing a dental home for all class members in the target population enrolled in Texas Health Steps. The FDH initiative provides opportunities for early intervention and prevention of dental disease. The goal of the Oral Evaluation and Fluoride Varnish in the Medical Home Initiative, implemented in September 2008, is to work with Texas Health Steps medical checkup providers to introduce class member parents/caregivers to the importance of early dental care.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	47.3	25.1	23.0	22.0	22.4
Numerator	35758	21088	21145	21652	23493
Denominator	75528	83891	91874	98409	104971
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

All SSI recipients in Texas obtain health care benefits coverage through Medicaid. Considering the broader spectrum of comprehensive rehabilitation and habilitation services, the form reflects SSI recipients who are provided outreach and case management services through CSHCN Title V efforts.

Notes - 2008
All SSI recipients in Texas obtain health care benefits coverage through Medicaid. Considering the broader spectrum of comprehensive rehabilitation and habilitation services, the form reflects SSI recipients who are provided outreach and case management services through CSHCN Title V efforts.

Notes - 2007
All SSI recipients in Texas obtain health care benefits coverage through Medicaid.

Considering the broader spectrum of comprehensive rehabilitation and habilitation services, the form reflects SSI recipients who are provided outreach and case management services through CSHCN Title V efforts.

Narrative:
All SSI recipients in Texas obtain health care benefits through Medicaid. In considering the overall spectrum of comprehensive rehabilitation and habilitation services, the form reflects SSI recipients who are provided outreach, intake, case management and other support services through DSHS central and regional staff. The percentage decreased some in 2006 due to standardizing the definition and reporting of case management services. However, the percentage has stabilized over the last few years. In Texas, CYSHCN includes children from birth up to age 21; therefore the count of SSI recipients served by DSHS staff may include some SSI recipients who are 16 through 20 years of age, although these recipients are thought to represent a very small percentage of the whole.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2006	payment source from birth certificate	9.5	7.7	8.5

Notes - 2011
Source: 2006 Final Natality File

Narrative:
In 2006, the rates of low birth weight were 23.4% higher in the Medicaid population than in the non-Medicaid population. Rates in both groups continue to exceed the Healthy People 2010 Objective of 5%. The percent of infants born low birth weight increased overall by 1.8% from 2005. The Medicaid population experienced a greater increase in the percentage of infants born low birth weight (2.3%) than the Non-Medicaid population (1.6%) from 2005 to 2006.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2006	matching data files	6.7	5.4	5.9

Notes - 2011
Infant mortality reported here differs from the infant mortality rate reported for 2006 from Form 12, Outcome Measure 1. This occurs because only infants deaths for which a matching birth certificate can be identified are included in the numerator.

Source: Matched Final 2006 Natality File and 2006 Mortality File.

Narrative:
Regardless of Medicaid status, the infant mortality rates among all groups exceeded the Healthy People 2010 Objective of 4.5 infant deaths per 1,000 live births. However, the overall rate in Texas and the rate among non-Medicaid participants were lower than the national rate in 2006, and was the same for the Medicaid participants (6.7 infant deaths per 1,000 live births). The infant mortality rate was 24.1% higher among Medicaid participants. The infant mortality rates decreased overall from 2005 to 2006 and for the Medicaid and non-Medicaid populations. Planning focused on sleep safety for infants, including collaboration with the Texas Department of Family and Protective Services (DFPS) continued in FY09 through a cross agency work group called the Infant Health Workgroup. In addition, DSHS has partnered with DFPS on two safe sleep projects, including an online training for CPS caseworkers in assessing a sleep environment for safety when working with a family. This training will be required of CPS caseworkers and supervisors. The second project is a pilot project and includes a train-the-trainer targeting community level providers working with families. In addition to these projects, the Information for Parents of Newborns booklet about SIDS prevention and safe sleep is available on the DSHS website. Activities promoting safe sleep practices, especially in low-income populations, may help to reduce the overall infant mortality rate and the disparity between Medicaid and non-Medicaid participants.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	payment source from birth certificate	52.8	66.2	60.6

Notes - 2011
In 2005, Texas implemented the US Certificate of Live Birth, 2003. This change had a significant impact on measures of prenatal care utilization.

Source: 2006 Final Natality File

Narrative:
While the change in the birth certificate in Texas in 2005 impacts multi-year measures, assessing the relative differences between groups should not be impacted by this change. The proportion of women enrolled in Medicaid who received first trimester care was 25.4% lower than women not enrolled in Medicaid. This gap has been increasing over the past several years. Both the Medicaid and non-Medicaid populations fail to meet the 90% standard set in Healthy People 2010. Future activities need to continue to focus on outreach and informing activities specific to the Medicaid population and to improve pregnancy planning.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2006	payment source from birth certificate	57.9	64.7	61.8

Notes - 2011
In 2005, Texas implemented the US Certificate of Live Birth, 2003. This change had a significant impact on measures of prenatal care utilization. The proportion for all reported for this measure does not match the proportion reported for 2006 for HSCI #04. The data presented here are from the 2006 final Natality file compared to HSCI #04 which presents data from a preliminary 2006 Natality file. The TVIS does not allow for the correction of the 2006 data in HSCI #04.

Source: 2006 Final Natality File

Narrative:
While the change in the birth certificate in Texas in 2005 impacts multi-year measures, assessing the relative differences between groups should not be impacted by this change. The proportion of women enrolled in Medicaid who received adequate prenatal care was 11.7% lower than women not enrolled in Medicaid as determined by the Kotelchuck Index. The gap in prenatal care use between non-Medicaid and Medicaid populations is less when using the Kotelchuck Index compared to enrollment in the first trimester. This may suggest that while women receiving Medicaid do not enter prenatal care early, once entered, they receive the adequate number of visits.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06	**YEAR**	**PERCENT OF**

The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.		**POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	200

Narrative:
Medicaid eligibility in Texas surpasses the Federal Medicaid mandate of 133% FPL. CHIP further expands coverage to infants whose families are 200% FPL or below are eligible for CHIP in Texas. This standard is the most common eligibility standard throughout the country.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2009	 133 100
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2009	 200

Narrative:
Eligibility requirements for children ages 1 through 5 satisfy minimum acceptable standards established by federal Medicaid regulations. Texas also includes coverage for children 6 through 18 and in situations of extreme poverty also covers young adults ages 19 and 20, neither of which is mandated by federal Medicaid regulations. Children ages 1 through 19 whose families are 200% FPL or below are eligible for CHIP in Texas. This standard is the most common throughout the country.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**

Pregnant Women	2009	200

Narrative:
Texas provides Medicaid coverage to pregnant women by exceeding the federally mandated 133% FPL and allowing coverage up to 185% FPL. Since FY07, CHIP also provides care to pregnant women up to 200% FPL who are not eligible for Medicaid.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	2	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Yes
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	2	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011

Narrative:
Infant Birth and Death Certificates
DSHS currently has the capacity to link birth and death records and perform analyses for program planning and policy formulation purposes. DSHS has the responsibility for vital statistic registration in Texas. Data are readily available.

Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims files
DSHS currently has the capacity to link birth records and Medicaid data. Texas requires significant time/resources to manage/link the data due to 400,000 births and millions of Medicaid

eligibility records and/or claims generated per year.

Annual linkage of birth certificate and WIC eligibility files
DSHS currently has the capacity to link birth certificate and WIC data. WIC data are readily accessible and birth record extracts for PRAMS are linked monthly to improve contact information of potential respondents in order to increase response rates.

Annual Linkage of birth certificate and newborn screening files
Texas Newborn Screening currently tests for 28 disorders. Texas Early Hearing Detection and Intervention (TEHDI) Program is the State's universal newborn hearing screening, tracking and intervention program. Hospitals with obstetric services and birthing facilities with 100 or more births per year located in counties with population >50,000 are legislatively mandated to offer newborn hearing screening.

Hospital Discharge Surveys
The Texas Health Care Information Council (THCIC) has responsibility for collecting hospital discharge data from all state licensed hospitals except those that are statutorily exempt from reporting requirements (those located in counties with a population <35,000 or counties with a population >35,000 but <100 licensed hospital beds). The data are administrative rather than clinical. Final data files are ~2 years behind and contain ~95% of all hospital discharges. Linking to Hospital Discharge data is not legal in Texas.

Annual Birth Defects Surveillance
Texas Birth Defects Registry is a population-based registry, which collects statewide data on pregnancies affected by birth defects. The registry is based upon active surveillance of infants and fetuses with birth defects born to Texans. The Registry became statewide starting with 1999 births. Records based on abstracted medical information are matched to vital records filed with the vital records.

PRAMS
The Pregnancy Risk Assessment Monitoring System (PRAMS) is a CDC sponsored initiative to reduce infant mortality and low birth weight. PRAMS is an on-going state specific population-based surveillance system designed to identify and monitor selected maternal experiences before, during and after pregnancy. A sample of ~200 mothers is drawn monthly from the birth records. PRAMS uses mixed mail and telephone modes to conduct interviews with biological mothers of infants aged 60-180 days old. Texas initiated PRAMS in 2002, and is currently one of 38 states participating.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	**Does your state participate in the YRBS survey? (Select 1 - 3)**	**Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)**
Youth Risk Behavior Survey (YRBS)	2	Yes
Behavioral Risk Factor Surveillance System (BRFSS)	3	Yes
Pregnancy Risk Assessment Monitoring System (PRAMS)	2	Yes
Texas School Surveys	3	Yes

Notes - 2011

Narrative:
Youth Risk Behavior Survey

Current Status: The Youth Risk Behavior Survey (YRBS) is one component of the CDC epidemiologic surveillance system developed to monitor the prevalence of youth behaviors that influence health. DSHS has direct access to and the capacity to analyze this database. YRBS is conducted biennially in selected metropolitan areas and only students in the 9th-12th grade in private and public schools are sampled. Therefore results may not be representative of non-metropolitan areas and data cannot be used for regional estimates.

Texas School Survey

Current Status: Texas Commission on Alcohol and Drug Abuse (TCADA) in collaboration with the Public Policy Research Institute at Texas A&M University conducted two statewide surveys of drug and alcohol use among students in elementary and secondary schools. Reports of these surveys are currently available for 1988 through 2006. Surveys are only conducted in public schools therefore private school students and dropouts are not represented in the sample. Estimates of substance use in this survey are based on self-reports.

Behavioral Risk Factor Surveillance System

Current Status: The Behavioral Risk Factor Surveillance System (BRFSS) is one component of the CDC epidemiologic surveillance system developed to monitor the prevalence of behaviors among adults (ages 18 and older) that influence health. For the 2007, 2008, 2009 and 2010 BRFSS administration in Texas, questions were added that addressed breastfeeding, family planning, and oral health. DSHS has direct access to and the capacity to analyze these data. Additional funding has allowed for oversampling among Texas' border populations which should yield new information useful to programs. All data are self reported through telephone interviews.

PRAMS

Current Status: While DSHS has direct access to these data, Texas PRAMS does not currently meet CDC's requirement of a 65% response rate per sample strata. The response rate for Texas PRAMS in 2008 was 64.5%. Texas hopes to make it into the national sample in 2009 and will continue to explore ways to increase participation rates. PRAMS data are collected statewide and available data cannot be used for regional or local estimates. All data are self-reported. Currently, data analyses are being conducted internally to influence policy and service delivery in the Title V program.

IV. Priorities, Performance and Program Activities
A. Background and Overview

At a time when budgets are constrained and resources are limited while the demand for services increases, priorities and performance measures guide Title V staff to focus program efforts and available resources on activities that are critical to improve the health and well-being of women and children in Texas. Along with the established outcome measures, performance measures ensure accountability, promote efficiency, and provide comparisons to other states. Together, the measures also provide both short-term goals and a long-term vision for maternal and child health in the state. Linking the two ensures that activities designed to advance the state toward meeting short-term performance goals will lay the foundation and initiate progress toward achieving long-term outcome measures for Texas and the nation.

As previously described, in conducting the FY11 Title V Five-Year Needs Assessment, DSHS made considerable efforts to ensure that stakeholder input was direct and inclusive of as many partners, providers, consumers, and other stakeholders interested and impacted by MCH issues as possible. The process incorporated a wide variety of methods and venues to gather input from and establish ongoing communication with stakeholders: community meetings, state-level meetings, group presentations, web-based surveys, facilitated exercises, email communication, newsletter articles, and website information.

The extensive stakeholder input process resulted in a ranked list of 24 recommended need statements. The Needs Assessment Planning Group reviewed the statements in the context of the quantitative data that was gathered and then consolidated them based on similarities of populations, services, or functions. Based on the themes that emerged, the group formulated 10 priority needs for the State of Texas. All three MCH populations are included in the new priorities and aspects of prevention, primary care, and services for CYSHCN have been woven throughout the set. The priorities focus on the areas of:

- Access to care across the life course,
- Mental health and substance abuse,
- CYSHCN transition,
- Dental care,
- Healthy child and adolescent development,
- Essential enabling services,
- CYSHCN community-based systems of care,
- Population-based health promotion and disease prevention,
- Health care provider workforce development and retention, and
- Evidence-based interventions.

Informed by these priorities, Title V staff, in partnership with other DSHS MCH-related program staff, revised state performance measures and developed FY11 activity plans to address the needs identified during the needs assessment process and continue work on improving the health and well-being of the MCH population. Throughout the project year, Title V staff will continue to work closely with DSHS staff from partnering programs to support the implementation of these planned activities and monitor progress towards meeting the FY11 performance goals.

The MCH service level pyramid guides Title V staff on how efforts are ideally proportioned across direct health care, enabling services, population-based services, and infrastructure building services to ensure that there is an appropriate balance of funds that reflect the different needs in Texas. Under the direct oversight of the State Title V Director, ongoing efforts to accurately track Title V expenditures using specific budget program codes that stratify services by population and pyramid service level have led to improved reporting and allocation planning. These efforts have also allowed for the opportunity to fund one-time projects, limited in scope and duration, to

address immediate needs in the state with the confidence that by doing so the federally-required funding expenditure allocations will not be compromised.

Outcome measures are another means to convey progress and accountability in achieving program goals. In FY09, Texas met three of the six national outcomes measures concerning fetal, infant, and child mortality. Those met included the postneonatal mortality rate per 1,000 live births, the perinatal mortality rate per 1,000 live births plus fetal deaths, and the child death rate per 100,000 children aged 1-14. The remaining three outcome measures were not met, although there was improvement in two. The two unmet but improved outcomes were the infant mortality rate per 1,000 live births and the neonatal mortality rate per 1,000 births. From 2005 to 2009, there was no change in the ratio of the Black infant mortality rate to the White infant mortality rate and a slight worsening in the ratio of the Black perinatal mortality rate to the White perinatal mortality rate. The indicators on infant mortality identify the challenge that Texas continues to face in reducing the mortality outcomes for infants less than 28 days of age, especially among Black infants. Since the research literature links these outcomes to maternal health and the adequacy of prenatal care, DSHS will continue to implement activities that target populations where these risk groups are most prevalent.

Title V services provided by DSHS are intended to promote health and well-being, as well as to positively affect the national outcome measures. While the affect of these activities on the outcome measures is often cumulative, descriptions of Texas' more immediate progress on the national and state performance measures are provided in this section under C. National Performance Measures and D. State Performance Measures.

B. State Priorities

The FY11 Five-Year Needs Assessment stakeholder input process collected public comment that resulted in recommended needs statements for maternal and child health in Texas. The Needs Assessment Planning Group, including the Title V MCH and CSHCN Directors, reviewed the needs statements gathered and sorted them into groups based on similarities of populations, services, or functions, leading to a list of 10 priority needs. While there may be some concern that the new priorities are either too broad or cannot be solely addressed through the efforts of Title V funding, they are meant to serve as a framework that can be used as a consistent guide for the future. The department's ability to respond to the rapidly-changing health care environment requires broad vision and flexibility. The state priorities easily can be linked to the four service levels of the MCH services pyramid: Direct, Enabling, Population-Based, and Infrastructure Building. All three MCH target populations are included in the priorities and aspects of prevention, primary care, and services for CYSHCN have been woven throughout the set.

The 10 Texas Title V priorities and their associated MCH pyramid level and performance measures are discussed below. The order of the items is not a ranking by importance, as all are considered of equal value. For reference, the FY11 National and State Performance Measures (NPM/SPM) are:

NPM 1 -- The percent of screen positive newborns who received timely follow-up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

NPM 2 -- Percent of CSHCN (0-18 yrs) whose families partner in decision making at all levels and are satisfied with services they receive.

NPM 3 -- Percent of CSHCN age 0-18 who receive coordinated, ongoing, comprehensive care within a medical home.

NPM 4 -- Percent of CSHCN age 0-18 whose families have adequate private and/or public

insurance to pay for the services they need.

NPM 5 -- Percent of CSHCN age 0-18 whose families report the community-based systems are organized so they can use them easily.

NPM 6 -- Percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life.

NPM 7 -- Percent of 19-35 mo. olds who have received full schedule of age appropriate immunizations against MMR, Polio, Diphtheria, Tetanus, Pertussis, HIB and Hep B.

NPM 8 -- Rate of birth (per 1,000) for teenagers aged 15 through 17 years.

NPM 9 -- Percent of 3rd grade children who have received protective sealants on at least one permanent molar tooth.

NPM 10 -- Rate of deaths to children aged 14 yrs and younger caused by motor vehicle crashes per 100,000 children.

NPM 11 -- Percentage of mothers who breastfeed their infants at six months of age.

NPM 12 -- Percentage of newborns who have been screened for hearing before hospital discharge.

NPM 13 -- Percent of children without health insurance.

NPM 14 -- Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

NPM 15 -- Percentage of women who smoke in the last three months of pregnancy.

NPM 16 -- The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

NPM 17 -- Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

NPM 18 -- Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

SPM 1 -- Change in percentage of CYSHCN living in congregate care settings as percent of base year 2003.

SPM 2 -- Rate of excess feto-infant mortality in Texas.

SPM 3 -- The extent to which programs enhance statewide capacity for public health approaches to mental and behavioral health for MCH populations.

SPM 4 -- The percent of women between the ages of 18 and 44 who are current cigarette smokers.

SPM 5 -- The percent of obesity among school-aged children (grades 3-12).

SPM 6 -- Rate of preventable child deaths (0-17 year olds) in Texas.

SPM 7 -- The extent to which research findings and/or evidence-based practices are used to develop and improve DSHS programs serving MCH populations.

PRIORITY: SUPPORT AND DEVELOP HEALTH CARE INFRASTRUCTURE THAT PROVIDES COORDINATED ACCESS TO SERVICES IN A CULTURALLY COMPETENT MANNER, ADDRESSING HEALTH ISSUES ACROSS THE LIFE COURSE (Direct & Infrastructure Building).

During the stakeholder input process for the FY11 Five-Year Needs Assessment, the most frequently mentioned needs were those pertaining to access to coordinated, holistic health care for the MCH population. Texas has one of the highest percentages of uninsured children in the nation. According to the Texas Office of the State Demographer, there were approximately 1.5 million, or 24%, of the population birth to 17 years of age who were uninsured in 2010. Nearly two-thirds of Texas' uninsured children come from low-income families who may be eligible for CHIP or Medicaid. Additionally, 36.5% of women of childbearing age (18 to 44 years) reported they had no health care coverage and 30.4% reported not seeing a doctor due to cost. Challenges with accessing health care services may contribute to the percent of low birth weight babies (8.5% in 2006), the percent of infants born preterm (13.6% in 2006), and the rate of infant mortality (6.2 infant deaths per 1,000 live births in 2006).

PMs related to this priority: NPMs 3, 4, 5, 13, 17, 18, and SPM 2

PRIORITY: INCREASE THE AVAILABILITY OF QUALITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES (Direct & Infrastructure Building).

Mental health counseling and other related services are important resources for many women and children in Texas. Research confirms that women suffer from depression and depressive symptoms more frequently than men. They also seek out mental health services more often than men. Findings from the 2007 Texas Behavioral Risk Factor Surveillance System (BRFSS) Survey showed that approximately one in five women of childbearing age reported that they felt sad, blue, or depressed on one or more of the preceding 30 days while 23% reported that a mental illness or emotional problem kept them from doing their work or usual activities.

Many children struggle with emotional or behavioral problems. According to the National Survey of Children's Health (NSCH), among Texas children 2 to 17 years of age, 2.4% are currently diagnosed as developmentally delayed with a condition that affects their ability to learn. The 2005/2006 NS-CSHCN reports that 3.1% of CSHCN in Texas have ongoing emotional, developmental, or behavioral conditions. Furthermore, many children and adolescents who need mental health counseling do not receive it. The 2007 NSCH reports that in Texas, 4.7% children and adolescents received counseling from a mental health professional in the past year, yet 12.2% have an unmet need related to mental health care.

PMs related to this priority: NPMs 3, 4, 5, 6, 15, 16, and SPMs 3, 4

PRIORITY: INCREASE THE NUMBER OF YOUTH WITH SPECIAL HEALTH CARE NEEDS WHO RECEIVE NECESSARY SERVICES TO TRANSITION TO ALL ASPECTS OF ADULT LIFE (Enabling).

Successful transition to all aspects of adult life lays a foundation for long-term individual and family physical and mental health and wellness. Federal laws require that transition formally be addressed in both education and vocational rehabilitation. Often times health care transition, which, at minimum, involves changing from pediatric to adult providers and includes having the knowledge and skills to manage one's own care and adequate resources to pay for care, is overlooked by providers and families alike. From the 2005-2006 NS-CSHCN, 37.1% of Texas CYSHCN (13 to 17 years of age) receive the services necessary to make transitions to all aspects of adult life.

PMs related to this priority: NPM 6

PRIORITY: INCREASE ACCESS TO DENTAL CARE (Direct & Infrastructure Building).

According to the National Survey of Children's Health, 78.4% of Texas children saw a dentist for preventive care within the past 12 months. There are several reasons why many women do not visit a dentist or take their children to a dentist. Among women in Texas with incomes below $25,000 a year, barriers to receiving dental care are cost (62.5%), no reason to go (13%), dentist does not accept my insurance, (3%), fear or nervousness (2%), and no appointments available (1%).

Within the last 12 months, 20.2% of Texas CYSHCN needed preventative dental care, and did not get it. Poor and uninsured children, children with lapses in insurance, and children with greater limitations had greater unmet dental care needs. In keeping with the acknowledged benefits of having a medical home, children with a personal doctor or nurse were less likely to have unmet dental care needs.

In 2010, 117 of Texas' 254 counties were determined to have too few dentists with more than 15 million (62%) Texans residing in these counties.

PMs related to this priority: NPMs 3, 4, 5, 9

PRIORITY: SUPPORT COMMUNITY-BASED PROGRAMS THAT STRENGTHEN PARENTING SKILLS AND PROMOTE HEALTHY CHILD AND ADOLESCENT DEVELOPMENT (Enabling & Population-Based).

According to the 2007 results from the Youth Risk Behavior Survey, Texas youth are at greater risk than youth across the US to engage in behaviors that contribute to the leading causes of death, disability, and social problems. This priority supports a comprehensive, evidence-based youth development approach to increase healthy behaviors and decision-making among Texas youth.

Additionally, this priority supports the value of fully incorporating the needs and knowledge of the family and of the child/adolescent into decision making throughout the service system. This includes active family participation in policy making for both local service delivery and state service systems. Providers serving children and adolescents, including CYSHCN, should recognize the importance of forming partnerships with families and learn about families' cultural norms, preferences, expectations, and needs.

PMs related to this priority: NPMs 2, 5, 14, and SPMs 1, 5, 6

PRIORITY: SUPPORT THE DEVELOPMENT OF COMMUNITY-BASED SYSTEMS THAT PROVIDE ESSENTIAL ENABLING SERVICES NEEDED TO IMPROVE HEALTH STATUS (Enabling & Population-Based).

Having community-based systems that provide culturally-appropriate, supportive social services necessary to enable families not only to access health care, but also to maintain follow-up care is critical to improving health status among the MCH population. Access to information regarding health and human services programs, transportation assistance, low-cost medications, affordable child care, and comprehensive case management services were all identified as needs in the FY11 Five-Year Needs Assessment.

PMs related to this priority: NPM 5 and SPMs 1, 3

PRIORITY: IMPROVE THE ORGANIZATION OF COMMUNITY-BASED SYSTEMS OF CARE FOR CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (Enabling & Infrastructure Building).

Community-based systems that are organized so that families of CYSHCN can use them easily are dependent not only on the availability of services, but also on their proximity and the means by which they are delivered. It includes such considerations as whether information about health and human services programs is easily understood and readily available; comprehensive case management services are available; programs are streamlined, comprehensive, coordinated and culturally competent; family support services such as respite, and home or vehicle modifications can be obtained easily; and families are satisfied with the services and supports they receive.

In Texas, the NS-CSHCN showed that the percent of CYSHCN whose families report that community-based service systems are organized so they can use them easily rose from 76.8% in 2001 to 88.2% in 2005-2006.

PMs related to this priority: NPM 5 and SPM 1

PRIORITY: USE POPULATION-BASED SERVICES INCLUDING HEALTH PROMOTION AND DISEASE PREVENTION INTERVENTIONS TO IMPROVE HEALTH OUTCOMES OF THE MCH POPULATION (Population-Based).

This priority is broadly stated in order to accommodate a variety of needs identified during the FY 11 Five-Year Needs Assessment process. These needs encompassed all types of population-based education and systems change needs involving topics such as immunizations, breastfeeding, obesity, violence prevention, teen pregnancy, and environmental contaminants.

PMs related to this priority: NPMs 1, 5, 7, 8, 10, 11, 12, 14, 18, and SPMs 2, 3, 4, 5, 6

PRIORITY: ENSURE ALL CHILDREN, INCLUDING CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS, HAVE ACCESS TO A MEDICAL HOME AND OTHER HEALTH CARE PROVIDERS THROUGH INCREASED TRAINING, RECRUITMENT, AND RETENTION STRATEGIES (Infrastructure Building).

The combined diversity of Texas' demography and geography creates challenges related to adequate access to health services. Sparsely populated areas experience challenges in recruiting and retaining health professionals. Furthermore, supply shortages are not limited to rural areas. Some inner-city areas include pockets of shortage designation areas where primary care is unavailable as well. Moreover, the number of providers may appear adequate in these areas, but access is limited based on non-acceptance of Medicaid or a patient's inability to pay for services.

In 2010, of the total 254 Texas counties, 189 counties were recognized as having too few primary care physicians including family practitioners, general practitioners, pediatricians, internists, or obstetrician/gynecologists; 117 were recognized as having too few dentists; and 194 were recognized as having too few mental health providers.

Additionally, in the 2005-2006 NS-CSHCN, 46.3% of Texas CYSHCN families indicated they receive coordinated, ongoing, comprehensive care within a medical home. This is less than the comparable 47.1% nationally, and less than the number reported in the 2001 NS-CSHCN.

PMs related to this priority: NPM 3

PRIORITY: PROMOTE THE EXPANSION OF NEW OR EXISTING EVIDENCE-BASED INTERVENTIONS TO ADDRESS MATERNAL AND CHILD HEALTH NEEDS (Infrastructure Building).

In recent years, there has been increased interest concerning the effectiveness and accountability of prevention and intervention programs. The increased demand for program quality, and evidence of that quality, has resulted in the need to identify and implement evidence-

based programs. Evidence-based programs are those where evaluation studies, subjected to critical peer review, have documented that the positive results can be attributed to the intervention itself, rather than to outside events. Efforts to incorporate evidence-based strategies when working with MCH populations can positively impact Title V state and national performance and outcome measures.

PMs related to this priority: SPM 7

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	377	370	433	470	656
Denominator	377	370	433	470	656
Data Source				Newborn Screening Database	Newborn Screening Database
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
Denominator is number of confirmed cases as indicated on Form 6.

Notes - 2008
Denominator is number of confirmed cases as indicated on Form 6.

Notes - 2007
Denominator is number of confirmed cases as indicated on Form 6.

a. Last Year's Accomplishments
Activity 1: In FY09, 406,813 specimens were reported. Approximately 1,700 were deemed unsatisfactory for an approximate 0.4% unsatisfactory specimen rate for initial specimens. The Texas Newborn Screening (NBS) program sent education materials to 405 providers: 150,344 NBS brochures; 245 Weight Conversion Charts; 171 Specimen Collection Guides; 445 Specimen Collection Posters; 53 CD Slide Presentations; 4,900 Newsletters; 19 ACT/FACT sheets; and 5,152 bookmarks.

NBS staff provided on-site education to enable health care providers to deliver timely and

appropriate screening of 27 disorders to all newborns. Information regarding NBS Remote Data Services was presented to health care providers. There were a total of 1,442 individual web user account sign-ups with 580 submitters for Remote Data Services. From September 2008-August 2009, training was provided to 2,032 providers and stakeholders. By Health Service Region (HSR), these include HSR 1 (15 trainings), HSR 2/3 (30), HSR 4/5N (2), HSR 6/5S (10), HSR 7 (37), HSR 8 (9), HSR 9/10 (5), and HSR 11 (3). NBS also worked with DSHS Laboratory Services to provide specimen collection training at 6 sites, including Abilene, Ennis, Lubbock, Odessa, Pampa, and Wichita Falls.

Urgent message notification cards were sent to more than 4,000 health professionals alerting them to specimen collection changes such as invalid dates and expired collection forms.

NBS Report Cards were sent quarterly by DSHS Laboratory Services to all facilities, physicians, and health care workers who submit newborn screening specimens. The report card provided statistics such as transit times from specimen collection to receipt in the laboratory, and the number of unsatisfactory specimens grouped by specific quality issues. For program comparisons, these report cards also included statistics from other submitters with similar birth totals and statistics from all Texas submitters.

The report card was used as a tool to monitor and improve specimen collection procedures for newborn screening, and to allow DSHS to identify sites that need educational tools or on-site training.

Activity 2: There were 480,125 hits to the NBS website in FY09. NBS sent 150,344 brochures, 405 posters, 5,052 bookmarks, and newsletters to over 5,000 stakeholders. NBS newsletters were sent to specimen submitters which include: OB-GYNs, midwives, birthing facilities, libraries, nursing schools, medical schools, endocrinologists, and metabolic specialists. 871 NBS providers accessed NBS online education modules, and 1,442 new web-based system users have been added for NBS online services.

Since December 2007, NBS has been notifying families of newborn children identified as having sickle cell trait. Families receive a certified letter from NBS as well as an educational brochure and a resource list of sickle cell associations in Texas. From September 2008-August 2009, 4,619 sickle cell trait notification letters were mailed to families.

Activity 3: In the 81st Legislative Session (2009), a bill was enacted to add safe sleep information to the Information for Parents of Newborns (IPN) publication. The IPN has been revised and a distribution plan was created. New information was added about car seat safety, CYSHCN, Early Childhood Intervention, and other topics. In FY09, there were 3,169 hits to the IPN website.

Activity 4: 5 stakeholder meetings were held in FY09. Fifty measures supported by peer-reviewed literature were identified for piloting. An impact and feasibility assessment was conducted to narrow the measures to be piloted. Eight focus groups with various stakeholders including hematologists, endocrinologists, geneticists, consumers, nurses, and hospital risk managers were held to assist with strategies for operationalizing measures and to provide input on reporting presentation of the performance measurement data. Using results from the focus group along with impact and feasibility assessments, executive sponsors finalized the list of measures to pilot in FY10.

Performance Assessment: Between 2004 and 2009, NBS met the annual objective of 100% follow-up and case management of identified presumptive positives even with the number of cases increasing. This was accomplished with increased awareness of the legal requirements for NBS and continued technical assistance to minimize the number of unsatisfactory tests.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Reduce the number of unsatisfactory specimens by identifying providers (hospitals, laboratories, clinics) who submit unsatisfactory specimens in order to provide them educational materials on specimen collection and handling procedures.			X	
2. Educate parents, including expectant parents and parents of newborn children, and health professionals about newborn screening benefit, state requirements, and importance of follow-up to positive tests by distributing brochures on newborn screening t			X	
3. Revise the Office of Title V publication Information for Parents of Newborns and make available on the MCH web page.			X	
4. Identify tangible measures that link the quality of patient care with the quality of pre and post-analytical stages of the newborn screening process.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: There were 198,010 newborn screening specimens, with 795 (0.40%) found unsatisfactory. There were 5,502 contacts made for unsatisfactory specimens. Education materials including 334 Weight Conversion Charts, 46 Specimen Collection Guides, 32 Spot Check Guides, 14 ACT/FACT sheets, 11 Specimen Collection Posters, 43 Newborn Screening specimen submitter packets, and 24 Slide Presentations were distributed.

Activity 2: Education efforts included distribution of 87,315 NBS Brochures, 74 NBS posters, and 1,490 bookmarks. 2,042 Sickle Cell Trait letters and 2,042 informational booklets were mailed. There were 254,849 website visits, 1,317 NBS and other health care providers accessed NBS online education modules.

Activity 3: Revisions to the booklet were completed in November 2009. Information on SIDS and Safe Sleep were added. The booklet was made available in English and Spanish online and in print.

Activity 4: Stakeholder meetings were held in November 2009 (Bandera) and February 2010 (Ft. Worth). At the November meeting, Draft Performance Measures (PM) Report was reviewed by NBS PM Project leadership. The final approval for the 21 PMs to be piloted in FY10 was received. At the February meeting, the team members began exploring interventions for the issues identified in the NBS Program. The completed PM Report was sent to CDC in January 2010. The queries for the final 21 PMs to be piloted were moved to the Laboratory Information Management Systems server.

An attachment is included in this section.

c. Plan for the Coming Year

Activity 1: Reduce the number of unsatisfactory specimens by identifying providers (hospitals, laboratories, clinics) who submit unsatisfactory specimens in order to provide them educational materials on specimen collection and handling procedures.

Output Measure(s): Percent of total newborn screens that are unsatisfactory; number of providers identified as submitting unsatisfactory specimens; number of contacts made with providers identified as submitting unsatisfactory specimens; number and type of educational materials distributed.

Monitoring: Monthly review of percent increase/decrease in unsatisfactory specimens and tracking of dissemination of materials.

Activity 2: Educate parents, including expectant parents and parents of newborn children, and health professionals about newborn screening benefits, state requirements, and the importance of follow-up to positive tests by distributing brochures on newborn screening to health care providers, providing Information for Parents of Newborn Children pamphlets for distribution by health care providers and facilities to all expectant and postpartum parents, placing information regarding newborn screening on the NBS Program website, and making an email address available for any questions regarding newborn screening.

Output Measure(s): Type and number of materials distributed and website hits.

Monitoring: Document distribution of materials and interactions with stakeholders.

Activity 3: Promote the prenatal distribution of Information for Parents of Newborns to provide parents with information about SIDS prevention, immunizations, shaken baby syndrome prevention, post partum depression, newborn screening, and other important resources.

Output Measure(s): Brochure available in English and Spanish, on the MCH web page and in hard copy.

Monitoring: Ensure posting of brochure on website and notification/distribution to key stakeholders.

Activity 4: Implement identified measures that link the quality of patient care with the quality of pre and post-analytical stages of the newborn screening process.

Output Measure(s): Establish evidence-based best practices in the areas of pre-and post-analytical stages of the newborn screening process that will serve as a model for nationwide replication. Investigate and document specific interventions and tools for which there is evidence or a demonstrable likelihood of effectiveness in improving performance/ quality in areas with noted deficiencies.

Monitoring: Track progress at regularly scheduled steering committee meetings.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**408374**			
Reporting Year:	**2009**			
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**	**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that**

					Received Treatment (3)	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	406813	99.6	113	13	13	100.0
Congenital Hypothyroidism (Classical)	406813	99.6	7407	203	203	100.0
Galactosemia (Classical)	406813	99.6	560	136	136	100.0
Sickle Cell Disease	406813	99.6	227	175	175	100.0
Biotinidase Deficiency	406813	99.6	245	38	38	100.0
Homocystinuria	406813	99.6	217	2	2	100.0
Maple Syrup Urine Disease	406813	99.6	58	1	1	100.0
beta-ketothiolase deficiency	406813	99.6	315	0	0	
Tyrosinemia Type I	406813	99.6	305	0	0	
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	406813	99.6	109	8	8	100.0
Argininosuccinic Acidemia	406813	99.6	51	1	1	100.0
Citrullinemia	406813	99.6	51	2	2	100.0
Isovaleric Acidemia	406813	99.6	146	2	2	100.0
Propionic Acidemia	406813	99.6	146	1	1	100.0
Carnitine Uptake Defect	406813	99.6	289	4	4	100.0
3-Methylcrotonyl-CoA Carboxylase Deficiency	406813	99.6	315	6	6	100.0
Methylmalonic acidemia (Cbl A,B)	406813	99.6	146	4	4	100.0
Multiple Carboxylase Deficiency	406813	99.6	315	0	0	
Trifunctional Protein Deficiency	406813	99.6	52	0	0	
Glutaric Acidemia Type I	406813	99.6	46	4	4	100.0
Hydroxymethylglutaric Aciduria	406813	99.6	315	0	0	
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	406813	99.6	146	19	19	100.0
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	406813	99.6	52	1	1	100.0
Methylmalonic Acidemia (Mutase Deficiency)	406813	99.6	146	3	3	100.0
Congenital Adrenal Hyperplasia	406813	99.6	5824	33	33	100.0

(Classical)						
Hearing Screening	2636386	645.6	45551	0	0	
Vision Screening	2733467	669.4	231914	0	0	
Spinal Screening	715560	175.2	23614	0	0	

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	57.3	57.4	57.5	58	58.1
Annual Indicator	57.0	57.0	57.9	57.9	57.9
Numerator	142384	142384	450786	450786	450786
Denominator	249840	249840	778339	778339	778339
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	58.2	58.3	58.4	58.5	58.6

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and 2005-2006 CSHCN survey. Numerator and denominator are weighted estimates.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. Numerator and denominator are weighted estimates.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. Numerator and denominator are weighted estimates.

a. Last Year's Accomplishments
Activity 1: CSHCN Services Program (SP) staff and contractors participated in family electronic mailing lists and local, regional, and state-level advisory groups. Family and other stakeholder input and concerns were identified through these and other forums. CSHCN SP central and regional staff and contractors attended 562 stakeholder meetings (attended by 21,680 participants, including 6,993 family members) and additional 2,873 community events/meetings. Key concerns of stakeholders continue to be: 6-month renewal requirement for Medicaid and CSHCN SP health care benefits, long wait lists for needed services/programs, and lack of

medical providers.

A former CSHCN SP staff member served as the Texas Family Delegate for AMCHP, and a CSHCN SP contractor was endorsed as an alternate representative.

The Texas Department of Aging and Disability Services (DADS) enhanced the Consumer Directed Services program by implementing "Support Consultation" services: coaching and training for persons with disabilities and/or their family members regarding their employer role in interviewing, hiring, or managing of providers. CSHCN SP staff gave input into role of the "support advisor," the provider of these services.

The Texas Department of Family and Protective Services and Texas Youth Commission have established family liaisons who partner in state policy decision making.

A Title V-funded contract with the Leadership Education in Adolescent Health (LEAH) program was initiated to support 50 families and youth/young adults with disabilities to attend the annual LEAH transition conference.

Activity 2: CSHCN SP contractors routinely solicited information from families of CYSHCN to gauge satisfaction with services and obtain recommendations for program improvements. Approximately 3,900 families responded to contractor satisfaction surveys with 98.2% indicating satisfaction on 75% or more of the survey questions. CSHCN SP enhanced the contractor evaluation process by developing four common core questions for each of the contractor family survey.

Activity 3: In conjunction with Title V Five-Year Needs Assessment activities, CSHCN SP developed surveys for families and providers and conducted stakeholder focus groups during contractor site visits, parent conferences, and other events. These efforts assessed satisfaction with services, unmet needs and gaps in services, and provided suggestions for improvement. Families submitted more than 500 completed survey forms. Forms were available in English and Spanish. 20% of surveys received were in Spanish. Survey results showed that the greatest unmet needs are for respite care, home modifications, payment sources for health care, special equipment, and help to find doctors and other services.

The 2008 Texas DADS Long Term Services and Supports Quality Review reported that families using the Community Living Assistance and Support Services Program with the Consumer Directed Option are more satisfied with services and children had greater access to health care.

Texas Parent to Parent with National Family Voices and Children's Policy Council made recommendations to the state legislature that resulted in: 1) increased funding to develop and implement the Medicaid buy-in program for children with disabilities with income up to 300% of the Federal Poverty Level; 2) higher standards for mobility aid providers; and 3) a reduction to the community-based waiting lists. A state-level Interagency Taskforce on Children with Special Needs was formed with family members in an advisory capacity.

Performance Assessment: The 2005/06 National Survey of CSHCN (NS-CSHCN) reported that 57.9% of Texas families of CYSHCN aged 0-18 responded that they are partners in decision making and are satisfied with the services they receive. Data indicated that Texas was on par with the national average. CSHCN SP contractor client/family surveys consistently reported high levels of satisfaction, 98%, with case management, clinical services, and family supports or community resource services. DSHS sought ongoing family input and participation in decision-making through stakeholder meeting reports, contractor reporting, parent focus groups, surveys, parent conferences, collaboration with Family Voices representatives, and the Texas Family Delegate to AMCHP. Family input was gathered as an essential component of the Five-Year Needs Assessment process to impact Texas Title V goals and activities prioritization.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support and enhance mechanisms for partnering in decision-making with families of CSHCN and promoting family networking.				X
2. Monitor consumer satisfaction with CSHCN Services Program contractor services.				X
3. Assess consumer satisfaction with CSHCN Services Program health care benefits and with state service systems in general.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: CSHCN SP contractors, central office, and regional staff reported attending 235 stakeholder meetings with participation by 2,053 family members. Key areas of interest for families include emergency preparedness and disaster planning, the Individual Education Plan (IEP) process, legal services, and behavioral/mental health services. Texas Parent to Parent launched an online support group specifically for fathers. The Children's Special Needs Network's Annual Conference included a "father's panel" to engage dads. CSHCN SP contractors collaborated with community organizations to provide supports for military families including person-centered training and respite.

Activity 2: CSHCN SP staff developed 4 core questions for the FY10 contractor family satisfaction surveys. Of 572 families responding, 567 are satisfied with access to services and information; 569 are satisfied with customer service; 569 are satisfied with family involvement in planning, delivery, and decision making; and 568 are satisfied with overall services.

Activity 3: Satisfaction surveys gathered data from parents and families of CYSHCN as part of the Five-Year Needs Assessment process. Results indicated a substantial need for transition services, respite, other family supports and help in using community based service systems. Families indicated a high level of satisfaction with partnering in decision-making and felt connected with the state service system.
An attachment is included in this section.

c. Plan for the Coming Year

Activity 1: Promote and support family input and partnership in decision-making at state, local, and individual levels of service planning and delivery.

Output Measure(s): Documentation of active CYSHCN/ family electronic mailing lists and key stakeholder groups with significant CYSHCN/ family membership (including contractor advisory groups); documentation of staff and contractor participation in stakeholder groups with significant CYSHCN/family membership; identification of key family input and impact on program activity planning (Annual Title V CYSHCN Activity Plan); documentation of training and other efforts to promote family involvement and partnership in decision-making at state, local, and individual levels.

Monitoring: Information from electronic mailing lists; Stakeholder Meeting Records and regional

meeting/events data; contractor quarterly reports of priority concerns/suggestions relevant to CYSHCN and their families; program discussions and use of family inputs in decision-making and activity planning; staff reporting of training; and other efforts.

Activity 2: Monitor consumer satisfaction with CSHCN SP contractor services.

Output Measure(s): Indicators of level of satisfaction with CSHCN SP contractor services such as contractor quarterly satisfaction survey results and the percentage of their clients who are satisfied with core topic areas as well as other services they receive through the contractor; priority concerns/suggestions relevant to CYSHCN from the contractor Stakeholder Meeting section of quarterly report; recommendations/input to contractors from consumers; and contractor response to consumer feedback.

Monitoring: Review contractor quarterly reports.

Activity 3: Assess consumer needs and satisfaction pertaining to health care benefits and state service systems.

Output Measure(s): Consumer satisfaction assessment activities implemented; data analysis; and recommendations made/actions taken based on results from stakeholder meeting records, contractor quarterly reports, focus groups, listening sessions, and surveys.

Monitoring: Satisfaction assessment efforts, progress, barriers, and results.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	58.6	58.7	58.8	46.4	46.5
Annual Indicator	58.3	58.3	46.3	46.3	46.3
Numerator	399631	399631	351768	351768	351768
Denominator	685206	685206	759974	759974	759974
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	46.6	46.7	46.8	47	47

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN

survey. The data for the two surveys are not comparable for PM #03. Numerator and denominator are weighted estimates.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03. Numerator and denominator are weighted estimates.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03. Numerator and denominator are weighted estimates.

a. Last Year's Accomplishments
Activity 1 - The Medical Home Workgroup (MHWG) met quarterly to identify progress made in implementing the strategic plan. Numerous medical home activities were presented and documented in meeting minutes.

CSHCN Services Program (SP) staff served on the Steering Committee for the Texas Medical Home Initiative, a patient-centered medical home project initially focused on adult practices. CSHCN SP plans to support adding transition best practices, objectives, and metrics to the adult practice pilots.

CSHCN SP awarded Medical Home Supports funding to four Texas pediatric and family physician practices in Harlingen, Houston, Amarillo, and Austin to apply practice-level medical home quality improvements. These practices accomplished activities related to emergency information forms, data management, and family advisory groups. Title V funds were used to provide additional medical home supports funding and to partner with the Leadership Education in Adolescent Health (LEAH) program to support transition clinic rotations for 12 internal medicine residents, annual transition conference attendance for parents/young adults, and to implement and evaluate a "transition module" in the electronic medical record for Texas Children's Hospital's pediatric clinics.

The Texas Medical Association and MHWG members from the Texas Pediatric Society sponsored a forum to discuss quality of care measures for CYSHCN. Stakeholders and key organizations convened to delineate a core set of evidence-based high priority health outcome measures that are best practices appropriate for implementation in all state programs.

The Texas Health and Human Services Commission began planning a strategic initiative to expand children's access to Medicaid services, a Health Home Pilot, with funding up to $25 million. Members of the MHWG were selected for the advisory expert panel.

A total of 857 health care professionals completed the Texas Health Steps Medical Home training module which was updated to include information on the National Committee for Quality Assurance Medical Home Recognition standards.

CSHCN SP implemented revisions to the Clinician-Directed Care Coordination Policy which provides reimbursement for face-to-face and non-face-to-face care coordination to allow reimbursement of telephone consults between specialists and primary care providers who are providing clinician-directed care coordination.

The Children's Health Care Principles submitted to the 81st Texas Legislature (2009) by the

CHIP Coalition included increased emphasis on medical home and goals relating to waiting lists, community-based behavioral health infrastructure, transition, dental coverage, health workforce, prenatal care, and early childhood development.

The Center for Public Policy Priorities (CPPP) reported on STAR Health, the managed healthcare program for foster children launched in 2008. The CPPP report documented FY09 efforts resulting in a strengthened Medical Home performance measure to be implemented in FY10 that will assess the percentage of primary care physicians (PCPs) operating according to the Medical Home Index model. The medical home concept is central to STAR Health's potential to improve health outcomes for foster children, 67% of whom have a chronic medical condition and up to 80% have diagnosable behavioral health or psychiatric conditions.

Activity 2: 97.6% of CYSHCN receiving case management and clinical services from CSHCN SP regional staff and contractors had a PCP. Of CYSHCN with a PCP, 94.7% had seen their PCP in the past 12 months. Regional staff and contractors assisted 1,206 CYSHCN in establishing a medical home. Families and providers were educated on the medical home concept through conferences, grand rounds, and medical residency programs.

Performance Assessment: The 2005/06 National Survey of CSHCN reported that 46.3% of Texas CYSHCN aged 0-18 received coordinated, ongoing, comprehensive care within a medical home. This is somewhat below the national average. The measure is not comparable across survey years due to changes in survey questions. Increasing awareness and access to a medical home are priorities for CSHCN SP. MHWG, medical home supports funding, and major Texas initiatives have increased awareness of the medical home concept for families, physicians, third party payors, state agency personnel, and others.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide leadership to, and collaborate with members of the MHWG to increase awareness and knowledge of the medical home concept and practice among all relevant audiences and to promote medical home services and quality improvements.				X
2. CSHCN Services Program regional staff and contractors help CSHCN link to medical homes.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: The MHWG met quarterly with active discussion of multiple activities and initiatives and updates to the strategic plan.

Major medical home initiatives were launched in Texas: The Title V CSHCN Director joined the state team providing input for the Medicaid Health Home Pilot; participated in the National Academy for State Health Policy (NASHP) multi-state medical home consortium; and collaborated with the Texas Medical Home Initiative to include a transition-focus in the first pilots of the patient-centered medical home for adults.

CSHCN SP approved six proposals for "Medical Home Supports" funding to enhance medical home services for CYSHCN, including family-centered in-depth needs assessments; a resource guide with a transition module; a youth-led project to create a Transition Notebook; proactive care coordination and education to reduce emergency room visits and hospitalizations; enhanced Electronic Medical Record workflow tool to ensure patients receive preventative care; a mobile clinic and community partnership to develop a medical home; and a transition clinic in partnership with medical subspecialties.

A total of 229 professionals completed the Texas Health Steps Medical Home training module.

Activity 2: Contractors and regional staff assisted 456 families in finding a medical home. Of the 2,058 CYSHCN served who have a PCP, 1,983 have seen their provider this year.
An attachment is included in this section.

c. Plan for the Coming Year
Activity 1: Provide leadership to and collaborate with the Medical Home Workgroup (MHWG) and others to increase awareness, knowledge, implementation of, and access to quality medical home practice and integrated dental and mental/behavioral health services.

Output Measure(s): Progress on: MHWG strategic plan, MHWG minutes, and input from MHWG members; reimbursement of providers for Clinician Directed Care Coordination; development of core health outcome measures for CYSHCN across state programs; documentation of numbers of persons completing the DSHS Introduction to Medical Home training module; articles published in the Provider Bulletin and Family Newsletter; presentation schedule (conferences, seminars, and other venues); website postings to primary websites - CSHCN SP website and Texas page of AAP medical home website, and other relevant websites; development and dissemination of materials/tools information.

Monitoring: Review MHWG meeting minutes, provider billing and reimbursement data, Task Force for Children with Special Needs meeting minutes, DSHS training module data, relevant publications, presentations, and staff activity documentation.

Activity 2: CSHCN SP regional staff and contractors help CYSHCN access medical homes and integrated dental and mental/behavioral health services.

Output Measure(s): Number and percent of CYSHCN served by case management/clinical services contractors with a primary care physician (PCP) and who have seen their PCP in the past twelve months; number of CYSHCN assisted with establishing a medical home by regional staff and case management/clinical services contractors; staff and contractor activities to promote access to and integration of medical home, dental, and mental/behavioral health services; documentation of completion of the DSHS Introduction to Medical Home training module by contractors.

Monitoring: Review regional activity reports and contractor quarterly reports, DSHS training module completion certificates submitted by contractors.

Activity 3: Collaborate with the Medicaid Health Home Project and other initiatives to increase CYSHCN access to quality medical homes and integrated dental and mental/behavioral health services.

Output Measure(s): Documentation of the implementation and progress of the Texas Medicaid Health Home Project; documentation of the implementation and progress of other Medical Home initiatives, identifying any specific emphasis on integration of dental and mental health services; implementation of the transition component of the Texas Patient-Centered Medical Home Demonstration Project (Texas Medical Home Initiative).

Monitoring: Review of Medicaid Health Home Project and other initiative activity and data reports.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	52.9	54	54.1	58.3	58.4
Annual Indicator	52.9	52.9	58.2	58.2	58.2
Numerator	366173	366173	462528	462528	462528
Denominator	692198	692198	795137	795137	795137
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	58.5	58.6	58.7	58.8	58.9

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey. Numerator and denominator are weighted estimates.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey. Numerator and denominator are weighted estimates.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey. Numerator and denominator are weighted estimates.

a. Last Year's Accomplishments
Activity 1: CSHCN Services Program (SP) staff collaborated with agency workgroups to improve quality of care for CYSHCN. CSHCN SP aligned policy with Texas Health Steps (Medicaid/EPSDT) to implement improvements to preventive care medical checkups for children.

The Texas Health and Human Services Commission's (HHSC) strategic initiatives to increase access to preventive dental and medical services for children enrolled in Medicaid included: Mobile Dental Units providing 1,890 dental procedures; 13,413 children receiving oral evaluations and applications of fluoride; 106,621 children under three receiving benefits from the First Dental Home; and the Integrated Pediatric and Mental Health Program pilots providing 8,975 children in-

person contacts with mental health professionals at primary care offices.

HHSC obtained Centers for Medicare and Medicaid Services approval for the Youth Empowerment Services (YES) Medicaid waiver to provide community-based services to youth up to age 19 with severe emotional disturbance who would otherwise need in-patient psychiatric care.

HHSC also developed a loan repayment program to encourage physicians and dentists to provide care for children with Medicaid coverage. The program is the first in the nation to target pediatric specialists.

Texas' 81st legislature (2009) passed and funded the Family Opportunity Act Medicaid Buy-In Program to provide Medicaid for CYSHCN up to age 19 who meet eligibility criteria. The legislature also expanded the Deaf-Blind Multiple Disabilities waiver to include children and youth younger than age 18, increased health care benefits for children with Autism, and funded new home and community-based Medicaid waiver slots.

Activity 2: CSHCN SP provided health care benefits for 2,345 CYSHCN and helped 43 families pay for insurance in FY09. A total of 655 children were released from the waiting list for health care benefits. Due to funding limitations, 1,182 children remained on the waiting list including 248 with no other health coverage. The Texas Legislature provided funding to reduce the CSHCN SP waiting list for health care benefits in FY10-11. Staff worked to promote program enrollment of FQHCs and therapists as providers. DSHS regional staff and CSHCN SP contractors assisted families in accessing health insurance, including CHIP/Medicaid/CSHCN SP applications to prevent coverage lapses.

Activity 3: Staff attended stakeholder meetings for a statewide initiative, Healthy Texas, which begins in FY10 to help low-income working Texans purchase health insurance.

Activity 4: CSHCN SP published bulletins for families and providers that included resources on accessing and financing health care. The CSHCN SP client application packet was updated and simplified for ease of use in English and Spanish. Staff presented and exhibited at statewide conferences to share information with families and providers on accessing resources and heath care transition. Staff responded to family phone and email inquiries about Medicaid/CHIP, Medicaid Waivers, and CSHCN SP benefits. CSHCN SP contracted with the Leadership Education in Adolescent Health program to increase parent/young adult participation in the annual transition conference which provided families information on finding and financing health insurance.

CSHCN SP contractors sponsored conferences and participated in health fairs, coalitions, trainings, and other meetings to help families access health care and other support services. Performance Assessment: In the 2005/06 National Survey of CSHCN, 58.2% of Texas CYSHCN aged 0-18 reported having adequate private and/or public insurance to pay for needed services. Data suggests that Texas is moving in the right direction regarding this measure; however, the state continues to fall below the national average of 62%. New Medicaid Buy-In legislation and implementation of the YES Waiver create additional access to health care coverage for CYSHCN. The number of children and youth provided CSHCN SP health care benefits rose by 6% from FY08 to FY09 and the number on the waiting list decreased by 20%.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Pursue opportunities to collaborate with Texas Medicaid, CHIP, and other public/private health benefits providers and agencies to maximize health care coverage and quality				X

assurance parameters of such coverage for CSHCN.				
2. Maximize the provision of CSHCN Services Program health care benefits to eligible clients including: monitoring CSHCN Services Program health care benefits clients on the waiting list; payment of insurance premiums for clients on the CSHCN Services P	X	X	X	X
3. Explore opportunities to collaborate with employers and health plans about benefits and supports needed for employees who are parents of children with disabilities and employees with disabilities.				X
4. Provide information on public and private health insurance and financing of health care for CSHCN to families of CSHCN and providers and coordinate with Medicaid and CHIP to provide this information in their provider/family publications.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: The CSHCN Services Program (SP) Medical Home Supports grant awardees are required to become both Medicaid and CSHCN SP health care benefits providers. Enhancements were made to the CSHCN SP health care benefits Online Provider Lookup and Provider Enrollment Portal systems. HRSA awarded HHSC $50 million to provide cost sharing accounts to help low-income working Texans earning up to 300% FPL to buy insurance. The YES Medicaid waiver pilot began an interest list for children with serious emotional disturbances who need intensive community supports.

Activity 2: During the 1st half of FY10, 2,020 children received CSHCN SP health care benefits. 255 children were released from the waiting list. As of February 2010, 1,054 children were on the waiting list for health care benefits. Of these children, 248 had no other health care coverage. CSHCN SP assisted 33 families with insurance premium payments. Staff promoted enrollment of FQHCs and therapists as providers. DSHS regional staff and CSHCN SP contractors assisted families with CHIP, Medicaid, and CSHCN SP applications to prevent coverage lapses.

Activity 3: Staff exhibited at conferences and responded to inquiries about Medicaid/CHIP, Medicaid Waivers, and CSHCN SP benefits to help families and providers access resources. CSHCN SP contractors participated in conferences and health fairs to help families access health care.

An attachment is included in this section.

c. Plan for the Coming Year

Activity 1: Pursue opportunities to collaborate with Texas Medicaid, CHIP, and other payers to maximize health care coverage, evidence-based practices, and quality outcomes for CYSHCN.

Output Measure(s): Documentation of collaborative activities regarding health care coverage, evidence-based practices, and quality measurement and outcomes of these activities, e.g. collaboration regarding Medicaid and federal Health Care Reform initiatives.

Monitoring: Documentation of progress made on collaborative efforts. Ongoing identification of Federal Health Care Reform developments and assessment of impact for CYSHCN.

Activity 2: Maximize the provision of CSHCN SP health care benefits to eligible clients, pay insurance premiums when cost-effective, increase the number of providers, and monitor waiting lists.

Output Measure(s): Number of CSHCN SP health care benefits clients by age who were ongoing clients, received CSHCN SP health care benefits, on the waiting list, on the waiting list with no other source of insurance, and removed from the waiting list; number of CSHCN SP health care benefits clients who received Insurance Premium Payment Assistance (IPPA); number of CSHCN SP clients/families provided home modifications through the CSHCN SP family support services (FSS); number of CSHCN SP clients/families provided van modifications through the CSHCN SP FSS; documentation of efforts to increase number of CSHCN SP providers and outcomes of those efforts.

Monitoring: Review monthly CSHCN SP health care benefits client and provider data (from Texas Medicaid Health Care Partnership and program quarterly data summary reports).

Activity 3: Provide information to families, providers, and others on paying for health care for CYSHCN.

Output Measure(s): Articles published in CSHCN SP Family Newsletter and Provider Bulletins, and other publications; information posted on CSHCN SP website; informational materials shared via staff, contractors, or other means.

Monitoring: Review contractor quarterly reports; program articles published; and other means of communication.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	77.1	77.2	77.3	88.3	88.4
Annual Indicator	76.8	76.8	88.2	88.2	88.2
Numerator	193670	193670	706914	706914	706914
Denominator	252253	252253	801141	801141	801141
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	88.5	88.6	88.7	88.8	88.9

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05. Numerator and denominator are weighted estimates.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05. Numerator and denominator are weighted estimates.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05. Numerator and denominator are weighted estimates.

a. Last Year's Accomplishments
Activity 1: There were approximately 130,000 MCH-related calls to 2-1-1 Texas. The CSHCN Services Program (SP) January 2009 Newsletter for Families included information regarding registering with 2-1-1 Texas as part of emergency preparedness.

Activity 2: CSHCN SP central office and regional staff and contractors participated in 562 stakeholder meetings to assess and recommend improvements in policies and services. CSHCN SP staff and contractors attended or sponsored parent support events and used several of these venues to conduct needs assessment activities by distributing written surveys and/or holding focus groups.

CSHCN SP staff presented Title V information supporting family/youth involvement in decision making and system change to the Health and Human Services Commission, Office of Program Coordination for Children and Youth's Family Liaison meeting that discussed the various roles of staff and volunteers.

CSHCN SP contractor, Texas Parent to Parent, initiated plans for new parent teams in South Texas and the Dallas area to meet the needs of parents in underserved communities; held an annual parent conference with more than 400 attending; and worked with EMS personnel to develop training with special considerations for CYSHCN.

CSHCN SP contractor, Children Special Needs Network, held an annual parent conference and collaborated with the University of Texas Center for Disability Studies to provide special training and information to Fort Hood's military families of children and youth with special needs.

Education Service Center (ESC) Region 16 collaborated with CSHCN SP contractor, Coalition of Health Services, to sponsor the Panhandle Coalition for Transition Services. CSHCN SP staff collaborated with ESC 13 and others to develop an evidence-based pilot for schools to educate children with autism spectrum disorders using a family and professional team approach.

Texas received approval from the Centers for Medicare and Medicaid Services to implement the YES (Youth Empowerment Services) Medicaid Waiver in FY10, allowing flexible funding for community-based services and supports for 300 children with serious emotional disturbances and their families to prevent custody relinquishment and reduce or avert inpatient psychiatric hospital stays.

Activity 3: CSHCN SP staff partnered with Texas Health Steps (EPSDT) to update the Cultural Competency online training module, completed by 526 professionals. In FY09, CSHCN SP required program contractors to complete this training module and attained a 100% completion rate. CSHCN SP staff worked to ensure that contractors are able to communicate with clients in languages other than English. FY09 Medical Home Support grants strengthened infrastructure and enhanced use of translation programs for clinics. CSHCN SP staff presented at the 9th Annual African-American Family Support conference and attended the 3rd Annual Symposium of the Texas Association of Healthcare Interpreters and Translators. Children's Medicaid and CHIP held a first of its kind Spanish Telethon, yielding 800 calls and 400 applications.

Activity 4: CSHCN SP contractors and regional staff provided case management services for 14,495 CYSHCN. Staff responded to 16,761 requests for information and referrals. CSHCN SP staff assisted in revising the Texas Health Steps Case Management online training module and in redevelopment of the Case Management Transition Services module, to be implemented in FY10. Regional staff supported a six-year old client in publishing her "Wish Book" (see Attachment IV. C. NPM05 - Accomplishments).

Activity 5: CSHCN SP community-based contractors shared information via conference calls including outreach strategies, success stories, and workshops. During the Texas Parent to Parent Conference, a meet and share session was held to build collaboration among CSHCN SP contractors.

Performance Assessment: The 2005/06 National Survey of CSHCN indicated that 88.2% of Texas families of CYSHCN aged 0-18 reported that community-based services are organized so they can use them easily, slightly less than the national average. CSHCN SP staff and contractors continue efforts to improve easy access to community-based services through collaboration with other state and community-based partners. Client/family surveys provided through CSHCN SP contractors in FY09 consistently reported high levels of satisfaction with case management, clinical services, and family supports or community resource services.
An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate with Texas Information and Referral / 2-1-1 system to foster effective linking of CSHCN and their families to community services and supports.				X
2. Participate in interagency and intra-agency efforts to assess and improve state policies and programs that impact CSHCN and their families.				X
3. Continue and enhance use of appropriate languages and cultural approaches in publications and other interactions with CSHCN Services Program consumers.			X	
4. Provide case management through CSHCN Services Program.		X		
5. Enhance and promote collaboration among CSHCN Services Program Contractors.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Over 86,000 MCH-related calls were made to 2-1-1 Texas by mid-FY10, a 20% increase from mid-FY09.

Activity 2: HHSC and DADS developed a website to more easily search for Medicaid's long-term services. The website shows customer satisfaction info for Medicaid plans offering long-term care services.

CSHCN SP staff and contractors participated in numerous stakeholder meetings.

The legislatively mandated statewide Task Force for Children with Special Needs began. The DSHS Assistant Commissioner for Family and Community Health Services is an appointed member and chairs the Health Subcommittee. The Title V CSHCN Director has presented to the Task Force and is a member of the Health Subcommittee. Another CSHCN SP staff was appointed to the Transition Subcommittee.

Activity 3: The Texas Health Steps Cultural Competency training module was completed by 930 professionals.

The CSHCN SP Family Newsletter is published quarterly in English and Spanish and included articles on flu prevention, emergency and disaster planning for CYSHCN, and respectful language and modern terminology, e.g. "intellectual disabilities."

Activity 4: CSHCN SP provided case management for 5,018 CYSHCN. The following Texas Health Steps training modules were completed: 515 Case Management, 518 Mental Health, and 333 Mental Health Disorders.

Activity 5: CSHCN SP staff developed a targeted information activity for sharing successful initiatives and practices during quarterly contractor conference calls.
An attachment is included in this section.

c. Plan for the Coming Year
Activity 1: Collaborate with Texas Information and Referral/2-1-1 system to foster and improve effective awareness and linkage to community services and supports for CYSHCN and their families.

Output Measure(s): 2-1-1 service requests related to Maternal and Child Health; efforts to maintain and increase 2-1-1 family resources; and increase 2-1-1 staff understanding of CYSHCN issues.

Monitoring: Review quarterly 2-1-1 reports and collaborative efforts.

Activity 2: Participate in inter-agency, intra-agency and community efforts to assess and improve state policies, programs, and activities that affect CYSHCN and their families.

Output Measure(s): Groups in which CSHCN SP staff and contractors actively participate; review of Stakeholder Meeting Records to identify key issues, needs, and recommendations and inform Title V activity planning; completion of the DSHS Case Management training module by CSHCN SP staff, contractors, and others.

Monitoring: Review Stakeholder Meeting Records, contractor quarterly reports, annual Title V Activity Plan; DSHS training module data.

Activity 3: Enhance and promote the use of "People-First" language and use of appropriate languages, literacy levels, and cultural approaches in all communications regarding CYSHCN and their families.

Output Measure(s): Use of and efforts to promote use of "People First" language and appropriate literacy levels in publications, website content, and in interactions with stakeholders; bilingual publications and Spanish language content; completion of the DSHS Cultural Competency training module by CSHCN SP staff, contractors, and others.

Monitoring: Review media, staff activities, DSHS training module completion data, contractor technical assistance, site observations, communications, and quarterly reports.

Activity 4: Provide comprehensive case management, family supports, and community resources through the CSHCN SP.

Output Measure(s): Number of CYSHCN receiving case management, family supports and community resources from the CSHCN SP contractors, regional staff, and health care benefits.

Monitoring: Review contractor and regional quarterly activity reports and CSHCN SP health care benefits family support services data.

Activity 5: Promote collaboration, training and professional development opportunities related to the Title V performance measures for providers, clients, families and others.

Output Measure(s): Contractor information sharing during contractor conference calls to spread innovation and best practice; technical assistance and training provided for relevant groups.

Monitoring: Review contractor conference call minutes; training and technical assistance efforts and resource development.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		5.8	5.8	37.2	37.3
Annual Indicator	5.8	5.8	37.1	37.1	37.1
Numerator			107424	107424	107424
Denominator			289879	289879	289879
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	37.4	37.5	37.6	37.7	37.8

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data. Numerator and denominator are weighted estimates.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data. Numerator and denominator are weighted estimates.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data. Numerator and denominator are weighted estimates.

a. Last Year's Accomplishments
Activity 1: CSHCN Services Program (SP) regional staff and contractors provided transition planning for 1,139 CYSHCN. Support activities included sharing resources, updating web pages, publishing newsletters, and attending state and regional conferences or trainings. Staff assisted in the redevelopment of online transition training for case managers. The Center for Health Training reported that 93 completed the Transition Training for Case Managers developed in FY07. This is fewer than prior years; however, the training underwent major revision in FY09 and became the new Case Management Transition Services online module to be offered at no charge to a wide variety of professionals through Medicaid Texas Health Steps. CSHCN SP staff provided key subject matter expertise for the entire content of this revision.

Activity 2: Contractors provided services via brochures, local and regional workshops, interactions with high schools/students, parent/family future planning, and health provider access problem-solving. The number of contractors participating on the Transition Team increased from 7 to 12. CSHCN SP contracted with the Leadership Education in Adolescent Health (LEAH) program to support annual transition conference attendance for parents/young adults; transition clinic rotations for internal medicine residents; and evaluating a transition component for electronic medical records.

Activity 3: CSHCN SP staff worked on the Texas Parent to Parent 2009 Annual Conference Planning Committee, which developed and implemented a transition track for conference participants. During the conference, CSHCN SP staff presented to self-advocates and led the 3rd Annual Teen Transition Expo. Staff led an 8-week health care self-determination course for the Austin Resource Center for Independent Living and exhibited at the 2009 Youth Leadership Forum. Staff worked on conference planning for and provided resources to increase parent/young adult attendance at the 10th Annual Chronic Illness and Disability: Transition from Pediatric to Adult-Based Care Conference.

Activity 4: The Transition Team met bi-monthly to receive information, provide direction for program operations, and share resources. The Team developed a bilingual transition resource brochure, available in print and online. The Team reviewed feedback from stakeholder meetings that indicated needs remain for: improved agencies' coordination for supported employment; more family/parent training for health care transition and education transition

rights/responsibilities; and increased emphasis in medical homes in coordination with long-term care and community-based services.

Activity 5: CSHCN SP staff helped write and distribute the final House Bill 1230 Transition Workgroup, Legislative, and Monitoring Reports. Staff led planning for focus groups, surveys, and transition needs assessment activities. Staff created a statewide email list and regularly sent information to more than 250 people. After input from CSHCN SP staff, the Texas CHIP Coalition legislative policy priorities included support for transitioning CYSHCN from pediatric to adult medicine. Staff also provided input to other statewide transition initiatives, including the Texas Patient-Centered Medical Home (PCMH) Demonstration Project, the Texas Medical Home Initiative. This project may be the first of its kind to have a transition outcome component in an adult PCMH practice model.

Performance Assessment: The 2005/06 National Survey of CSHCN indicated that 37.1% of Texas youth with special health care needs received services necessary to make a successful transition to adult life, falling below the national average of 41.2%. This measure is not comparable across survey years due to changes in survey questions. Transition is a priority for CSHCN SP. Themes from stakeholder input inform Transition Team planning. There are ongoing efforts to improve transition case management; offer more information and training opportunities for families, case managers, providers, and others; collaborate with education and rehabilitation partners; and participate in state-level transition forums. DSHS benefits by partnering with LEAH grant activities. Staff expects that the Texas Medical Home Initiative will include CYSHCN transition to adult health care services in its FY10 demonstration project pilot.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide transition case management for CSHCN through CSHCN SP regional staff and contractors.		X		
2. Work with selected CSHCN SP contractors and staff to provide transition services and report on best and promising practices.				X
3. Partner with youth and adults with special health care needs and their families to share information and advise the CSHCN SP about transition activities.				X
4. Lead PHSU Transition Team to coordinate CSHCN SP transition activities.				X
5. Share resources, develop trainings, and collaborate on transition planning and promising practices.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Regional staff and contractors provided transition case management for 861 CYSHCN. 242 professionals completed the Texas Health Steps Case Management-Transition training module and 504 completed Adolescent Health Training.

Activity 2: Contractors continued transition services through various activities. CSHCN SP funded the LEAH Transition Program to support 49 family members to attend the LEAH Transition Conference; 3 internal medicine residents to complete a month of residency training in the Baylor College of Medicine Transition Clinic; and pilot implementation of an Electronic Medical Record

Transition Template in the Texas Children's Hospital outpatient clinics.

Activity 3: Staff helped plan the Texas Parent to Parent 2010 Annual Conference, including a Teen Summit, which expands the Teen Expo held 2007-2009 from one to two days and includes teens both with and without disabilities.

Activity 4: The Transition Team received and exchanged information about best practices and Medicaid Buy-In and Infrastructure Grant initiatives; conducted planning; and suggested future transition activities. The number of contractors participating on the Team grew to 13.

Activity 5: CSHCN SP staff exchanged information about transition with various audiences; participated in the Title V Five-Year Needs Assessment, including making transition a statewide priority; and was appointed to the Task Force of Children with Special Needs Transitioning Youth Subcommittee.
An attachment is included in this section.

c. Plan for the Coming Year
Activity 1: Provide transition case management for CYSHCN through CSHCN SP regional staff and contractors.

Output Measure(s): Resources provided to regional staff and contractors regarding transition; utilization of online or other transition case management training; number of CYSHCN receiving individual transition services from CSHCN SP contractors and regional staff.

Monitoring: Review transition training data; quarterly regional and contractor case management reports.

Activity 2: Partner with youth and adults with special health care needs, their families, and others to share information and advise the CSHCN SP about transition activities.

Output Measure(s): Youth, adult, and family advisors identified and input/guidance received on transition activities; survey of adults who were former CSHCN SP clients.

Monitoring: Review progress and results reports.

Activity 3: Lead the PHSU Transition Team, including CSHCN SP staff and contractors, to coordinate and enhance CSHCN SP transition activities.

Output Measure(s): Progress reports on Transition Team activities, products, and results; contacts with contractors to discuss transition activities, exchange information, and provide technical assistance to promote successful practices.

Monitoring: Review meeting minutes, publications, and progress reports, including contractor reports.

Activity 4: Contribute to or provide leadership, including training, to promote best and promising practices and to improve access to transition services and adult-serving providers in partnership with the LEAH program and other stakeholders.

Output Measure(s): Distribution of and updates to resource information; utilization of and updates to CSHCN SP web site transition page; information shared with CYSHCN, families, providers, and others via publications/ presentations; information reported at and outcomes or results from transition-related interagency and other meetings attended; participation in planning and attendance at meetings or conferences; identification of and contacts with adult-serving providers.

Monitoring: Review resource information shared, trainings developed, meeting minutes, stakeholder meeting records, and reports of other collaborative efforts.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	80	80	80	80
Annual Indicator	78.4	76.7	78.2	78.6	80.0
Numerator		412110	427369	431060	446806
Denominator		537301	546507	548422	558707
Data Source				National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	81	81	82	82	83

Notes - 2009
The percent immunized are from the National Immunization Survey http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#chart (accessed on 05/11/2010). Data from 2006, 2007, and 2008 are final. Estimates for 2009 are a linear projection using NIS data from 2002 through 2008.

Notes - 2008
The percent immunized are from the National Immunization Survey http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#chart (accessed on 05/11/2010). Data from 2006, 2007, and 2008 are final.

Notes - 2007
The percent immunized are from the National Immunization Survey http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#chart (accessed on 05/11/2010). Data from 2006, 2007, and 2008 are final. Estimates for 2009 are a linear projection using NIS data from 2002 through 2008.

a. Last Year's Accomplishments
Activity 1: The Texas Immunization Stakeholder Working Group (TISWG) continues to be a lead resource for active partnerships within the DSHS Immunization Branch. This statewide collaboration consists of the original 16 core members and representatives from DSHS, Health Service Regions, local health departments, state medical associations, parent groups, and immunization interest groups. TISWG met four times in FY09 (November 2008, February, June and August 2009). Topics included the response to H1N1 influenza outbreak and the response to

Hurricane Ike by the Vaccine Services program, the implementation of the recent law enacted to enter vaccination information on first responders into ImmTrac, the recent Haemophilus influenzae type b vaccine shortage, the five-year roadmap to improve vaccination against influenza, and potential legislation proposed for the 2009 state legislative session.

TISWG participants were provided the most current Centers for Disease Control and Prevention and DSHS information in preparation to respond to the season return of significant numbers of flu cases.

Immunization Branch contractors establish local partnerships within their jurisdictions such as the Houston Area Immunization Coalition or the Tulsa Area Coalition (Comal County).

Activity 2: The number of children under 6 years of age who participated in ImmTrac for FY09 is 478,470; the number of providers in the Vaccines for Children program for FY09 is 3,021.

Performance Assessment: The immunization rate in Texas increased gradually from 2007 to 2009. Texas' annual objective goal of 80% of 19-35 month olds who have received full schedule of age appropriate immunizations was reached in 2009. Continued activities include, but are not limited to, statewide distribution of vaccines, promotion of ImmTrac registration, well-checks provided through Title V contractors, provision of training and technical assistance, and the development and support of partnerships that can educate providers and promote adherence to immunization schedules in local areas.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Identify and develop partnerships with internal and external stakeholders to increase collaborative efforts to raise vaccine coverage levels.				X
2. Through provider and public training, technical assistance and education, promote the use of the state immunization registry, ImmTrac and the Vaccines for Children program.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: The Texas Immunization Working Group (TISWG) has not met since August 2009 due to the intensive activity surrounding the H1N1 influenza outbreak and the development of vaccine, but is scheduled to meet in May 2010.

Activity 2: 212,541 new children under 6 were entered into the ImmTrac system in the first half of FY10, and the current number of TVFC providers is 3,806.

An attachment is included in this section.

c. Plan for the Coming Year

Activity 1: Identify and develop partnerships with internal and external stakeholders to increase collaborative efforts to raise vaccine coverage levels.

Output Measure(s): Number and types of partnerships; summary report on efforts undertaken; current initiatives and outcomes or expectations.

Monitoring: Track the number and type of partnership activities.

Activity 2: Through provider and public training, technical assistance and education, promote the use of the state immunization registry, ImmTrac, and the Vaccines for Children program.

Output Measure(s): Number of state, regional, and local activities that promote participation in the state immunization registry, ImmTrac, and the Vaccines for Children program; number of materials produced.

Monitoring: Track number and type of activities, including quarterly Health Service Region reports; documentation on materials produced.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	37	37	37	32	32
Annual Indicator	35.3	33.7	34.9	33.8	34.4
Numerator	18092	17918	18449	18325	18201
Denominator	513133	531239	528403	542343	529384
Data Source				Natality Data and Office of State Demographer	Natality Data and Office of State Demographer
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	32	31.5	31.5	31	31

Notes - 2009
All natality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1991 through 2006.
Denominator data provided by the Office of the State Demographer.

Notes - 2008
All natality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1991 through 2006.
Denominator data provided by the Office of the State Demographer.

Notes - 2007
All natality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1991 through 2006.
Denominator data provided by the Office of the State Demographer.

a. Last Year's Accomplishments
Activity 1: With the abstinence education grant ending June 30, 2009, the program served 99,506 adolescents in FY09. DSHS served 13,901 adolescents (age 15-17) through Title V, X, and XX family planning contractors (46, 48, and 63 duplicated contractors, respectively). The number of adolescents served by each funding source include 707 (Title V), 1,570 (Title X), and 11,624 (Title XX). The DSHS Health Service Regions (HSRs) served 805 adolescents plus an additional 3,333 that were reached through awareness material distribution.
To raise awareness about adolescent pregnancy prevention, HSRs engaged in activities such as public service announcements, billboards, and active involvement with various coalitions and steering committees. The Texas School Health Network, which includes the 20 Education Service Centers (ESCs) served 7,263 community members (mostly students and some parents) through school assemblies and parent presentations, and 1,044 professionals (teachers, school administrators) were trained in abstinence-based curricula or programs.

Activity 2: Teen pregnancy data were presented at a Texas Association Concerned with School Aged Parenting (TACSAP) meeting. Texas Teen Birth Fact Sheets (2004 and 2005) were posted to the DSHS website, along with a supplemental podcast, describing race and age differences in teen birth outcomes for the state of Texas and the HSRs. Staff continued work on an Infant, Child, and Adolescent Health Report Card for the State of Texas, examining differences in race/ethnicity, gender, and age concerning adolescent birth outcomes and sexual risk taking behaviors.

Activity 3: A proposal for a comprehensive youth development intervention, the Texas Healthy Adolescent Initiative (THAI) was completed and a competitive request for proposals was posted in August. THAI was created to fund six communities to develop an adolescent health strategic plan using comprehensive youth development principles. THAI seeks to create a youth-focused environment in these communities and to build resiliency and increase protective factors among youth to improve their overall health and well-being and foster development so that youth become healthy and responsible young adults. Contracts for the THAI project will begin in FY10.

DSHS continued to work with the University of Texas at Austin on a research project to identify the knowledge, attitudes, and beliefs of adolescents, parenting and non-parenting males and females, and their parents to help inform the development of interventions to prevent adolescent pregnancy. At the end of FY09, 27 of the 48 focus groups had been completed in 3 out of the 4 selected cities across Texas. Official findings from the study will be available in FY10.

Performance Assessment: Consistent with slight declines across the nation, Texas saw a slight decrease in adolescent birth rates in 2008. However, the preliminary birth record data for 2009 indicates that this rate slightly rose again. As Texas' population continues to grow, the adolescent birth rate will continue to increase as the population changes. Activities should focus on the areas of the state with the largest population growth and with integrated efforts to build healthy decision making among adolescents.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase opportunities to engage in teen pregnancy prevention activities at the state and local levels.				X
2. Coordinate educational and awareness activities to increase understanding of teen pregnancy prevention, including disparities (racial/ethnic, geographic) in rates.			X	
3. Partner with external and internal stakeholders to identify opportunities and innovative interventions to prevent adolescent pregnancy.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activity 1: DSHS served 5,103 teens (17 and under) through Title V, X, and XX family planning contractors for the period November 2009 - February 2010. The Education Service Centers held 31 activities consisting of workshops, site visits, and coalition activities and provided information about teen pregnancy prevention to 4,658 people.

Activity 2: Three presentations on teen birth data and legal and programmatic implications were made at two conferences in October 2009. DSHS and Texas Education Agency received a National Stakeholders Collaboration project to address reproductive and sexual health disparities.

Activity 3: Focus group data from the Texas Teen Opportunity Project continue to be analyzed. The groups included parenting/non-parenting teens, young adults, and parents of teens to identify race/ethnic motivations for preventing teen pregnancy. Preliminary findings were provided to DSHS in October 2009.

Activity 4: DSHS regional staff engaged in population-based activities including work with School Health Advisory Committees, school districts, and coalitions to provide data and information. Staff provided health information for teens through presentations, health fairs, and referrals for health care services. Over 1,700 individuals were served through these activities.

Activity 5: The Texas Healthy Adolescent Initiative request for proposals was posted and six awardees in different communities were selected in November 2009; contracts began January 2010.
An attachment is included in this section.

c. Plan for the Coming Year
Activity 1: Increase opportunities to engage in teen pregnancy prevention activities at the state and local levels.

Output Measure(s): Number of procurement opportunities for teen pregnancy prevention service provision; number of Title V, X, and XX contractors; the number of teens (age 17 and under) receiving family planning services.

Monitoring: Review contractor quarterly and annual reports for number of clients served.

Activity 2: Coordinate education and awareness activities to increase understanding of teen

pregnancy prevention, including disparities (racial/ethnic, geographic) in rates.

Output Measure(s): Number, type, and format of activities implemented, including National Stakeholders Collaborative and YRBS fact sheets.

Monitoring: Copy of materials or products distributed; summary of annual events.

Activity 3: Partner with external and internal stakeholders to identify opportunities and innovative interventions to prevent adolescent pregnancy.

Output Measure(s): Number of meetings and types of partners engaged; developed proposals for implementation; implemented activities; number of Power2Wait toolkits distributed; number of Youth Leadership Clubs.

Monitoring: Review meeting notes; quarterly progress reports.

Activity 4: Coordinate and implement regional and local teen pregnancy prevention activities.

Output Measure(s): Number and type of activities coordinated by or implemented by Health Service Region Staff; number of teen pregnancy prevention activities provided through the Education Service Centers.

Monitoring: Review quarterly progress reports.

Activity 5: Implement Texas Healthy Adolescent Initiative in local communities.

Output Measure(s): Number of contractors; number and type of activities conducted by contractor.

Monitoring: Documentation of materials and plans developed; monthly progress reports.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	35	35	35	34.4	37
Annual Indicator	22.7	22.7	22.7	34.4	34.4
Numerator	67705	71225	72898	122241	126694
Denominator	298260	313768	321135	355351	368296
Data Source				Texas Education Agency	Texas Education Agency
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**

Annual Performance Objective	37	37	39	39	41

Notes - 2009
The 2007/2008 Texas Basic Screening Survey was used to estimate the percent of 3rd grade students who had protective sealants on at least one permanent molar. The numerator is estimated by applying this percent to the total number of 3rd grade students in Texas for 2009 (Source: Texas Education Agency; http://www.tea.state.tx.us/student.assessment/reporting/).

It is anticipated that Texas will conduct the next Basic Screening Survey in the 2011-2012 school year.

Notes - 2008
The 2007/2008 Texas Basic Screening Survey was used to estimate the percent of 3rd grade students who had protective sealants on at least one permanent molar. The numerator is estimated by applying this percent to the total number of 3rd grade students in Texas for 2008 (Source: Texas Education Agency; http://www.tea.state.tx.us/student.assessment/reporting/).

Notes - 2007
The DSHS 2004-2006 Statewide Basic Screening Survey was used to estimate the percent of 3rd graders who received sealants. This percent was then applied to number of 3rd graders in Texas for 2007 (source: Texas Education Agency; http://www.tea.state.tx.us/student.assessment/reporting/).

a. Last Year's Accomplishments
Activity 1: The DSHS Oral Health Program (OHP) provided preventive dental services to 10,748 children during FY09. Based on the 2007 Basic Screening Survey of a statistically representative sampling of 3rd graders in Texas, 34% have received dental sealants on at least one permanent molar.

Activity 2: OHP continues to monitor the number of 3rd graders with untreated caries through results of the 2007 Basic Screening Survey (BSS). This information is being used to guide programmatic decisions. The 2007 BSS data indicates that low-income, non-Medicaid 3rd grade children have less access to dental care than their low-income, Medicaid and middle- to high-income peers. This is evidenced by a higher percentage of low-income, non-Medicaid 3rd grade children who have fewer dental sealants, higher levels of untreated decay, and a lower percentage self-reporting that they have had a dental visit within the previous 12 months. As a result, OHP continued to offer preventive dental services to low-income preschool children as well as low-income children in pre-kindergarten through 2nd grade in an effort to reverse early, non-cavitated lesions and encourage parents to access dental services for their children.

Activity 3: Among Children's Health Insurance Program (CHIP) participants, there were 739,317 clients enrolled in the CHIP dental plan during FY09. Of those, 293,842 received dental services in FY09. The number for Medicaid Children (age less than 21) that had at least one dental service during FY09 was 1,645,220.

Activity 4: OHP continued to work with dental professional organizations including the Texas Dental Association, Texas Academy of Pediatric Dentistry, Texas Academy of General Dentistry, Texas Dental Hygienist's Association, the three Texas dental schools, and various dental hygiene programs across Texas to promote the utilization of preventive dental services for children, including the use of dental sealants. OHP staff held four quarterly Medicaid dental stakeholder meetings during FY09, during which the importance of providing preventive dental services to children enrolled in Medicaid has been discussed. OHP staff has also participated in Title V contractor teleconferences supporting the provision of preventive dental services to the population served. OHP also works with the Texas Head Start Collaboration Office and school nurses to promote the use of preventive dental services among preschool and school-aged children.

Performance Assessment: Analysis of BSS data indicated that continued efforts towards preventive dental services for non-Medicaid children are necessary. This is evidenced by a higher percentage of low-income, non-Medicaid 3rd grade children who have fewer dental sealants, higher levels of untreated decay, and a lower percentage self-reporting that they have had a dental visit within the previous 12 months.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue providing dental sealants to Texas third grade population statewide.	X			
2. Continue to monitor data on the numbers of third graders with untreated caries to use in guiding programmatic decisions.				X
3. Track number of children receiving dental care through Medicaid and Children's Health Insurance Program (CHIP) to use in guiding programmatic decisions.				X
4. Collaborate with multiple stakeholders to develop activities and materials to promote the use of dental sealants to both providers and recipients of services.			X	
5.				
6.				
7.				
8.				
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10.				

b. Current Activities

Activity 1: During the first half of FY10, the DSHS OHP regional dental teams provided preventive dental services to 7,135 children including 3rd graders. Of the 7,135 children, 2,644 received dental sealants. Preventive dental services include dental sealants when determined to be medically necessary and beneficial for the child.

Activity 2: DSHS OHP continues to use the results of the 2007 BSS which is a statistical sampling of 3rd graders in Texas to monitor the level of untreated dental caries. Of 2,583 non-Medicaid 3rd graders, 45% were found to have untreated decay and 72% had decay experience. Therefore, OHP regional dental teams continue to provide preventive dental services to low-income children in an effort to decrease the level of untreated decay and decay experience.

Activity 3: DSHS OHP regional dental teams continue to collaborate with public schools in Texas to offer free preventive dental services to low-income children. The regional dental teams also continue to collaborate with local health departments, dental hygiene programs, and Head Start programs statewide in order promote the use and provision of dental sealants.
An attachment is included in this section.

c. Plan for the Coming Year

Activity 1: Continue providing dental sealants to Texas school children.

Output Measure(s): Number of children who receive dental sealants.

Monitoring: Track progress of the data collection, analysis and reporting.

Activity 2: Monitor data on the number and percent of 3rd graders with untreated caries.

Output Measure(s): Summary of representative sampling data from regional dentists and other entities.

Monitoring: Analyze, interpret and report on data collected.

Activity 3: Increase access to preventive dental care services through school-based efforts.

Output Measure(s): Number of screenings provided, referrals made, and children with access to dental services through school-based health centers.

Monitoring: Analyze, interpret, and report on data collected; review quarterly progress reports.

Activity 4: Collaborate with stakeholders to develop oral health promotion activities and materials for providers and recipients of services.

Output Measure(s): Number and type of stakeholders involved in developing activities; number and type of materials developed; number and type of activities coordinated by regional staff.

Monitoring: Review of materials developed and distributed; review of quarterly progress reports.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.5	5.4	5.1	4.7	4.7
Annual Indicator	4.5	4.9	4.9	4.9	4.8
Numerator	234	260	261	261	261
Denominator	5185439	5287340	5332129	5356787	5427678
Data Source				Mortality Data and Office of the State Demographer	Mortality Data and Office of the State Demographer
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	4.6	4.6	4.5	4.4	4.4

Notes - 2009
All mortality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1999 through 2006.
Denominator data provided by the Office of the State Demographer.

Notes - 2008
All mortality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1999 through 2006.
Denominator data provided by the Office of the State Demographer.

Notes - 2007
All mortality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1999 through 2006.
Denominator data provided by the Office of the State Demographer.

a. Last Year's Accomplishments
Activity 1: In FY09, Safe Riders distributed a total of 21,645 safety seats to low-income families via 4 methods, all of which include an educational component for parents. 116 Child Seat Distribution and Education Program sites distributed 4,306 child safety seats at the conclusion of 1,760 child safety seat classes.

Safe Riders also provided 7,447 seats to community partner agencies that distributed child seats via checkup events and inspection stations with certified child passenger safety technicians. These agencies included Texas Children's Hospital (Houston), Hillcrest Baptist Hospital Kidsafe Program (Waco), Texas AgriLife Extension (multiple sites throughout Texas), Thomason Hospital (El Paso), Texans In Motion (Austin), Injury Prevention Center of Greater Dallas, Scott & White Hospital (Temple), and Brazos County Texas Department of Transportation District.

Safe Riders provided 4,896 seats to child passenger safety technicians to support 34 Child Passenger Safety (CPS) Week community events throughout Texas.

In response to new Texas legislation requiring the use of booster seats for children up to 8 years of age, Title V funding was used to provide 4,996 booster seats to community agencies for Give Texas a Boost, a program that sponsored many booster seat events throughout Texas.

Activity 2: Safe Riders conducted ten technician training courses where 290 students received their initial training or received their renewal training. Seven CPS technician training courses were held. 120 students completed the technician training. 170 students completed 1 of 3 renewal courses. Trainings were held in nine Texas cities. 13 DSHS regional MCH staff also received the CPS technician training in July 2009.

The technician training workshop that was conducted in Humble was audited by the quality control specialist with Safe Kids Worldwide, sponsor and manager for the national technician program. Safe Riders was given high marks for its management of the course. One of Safe Riders' innovative teaching techniques was brought out by the specialist during a session entitled "Conducting Quality Workshops" at Lifesavers national conference in Nashville during April.

Activity 3: Safe Riders conducted multiple presentations to adult groups about child passenger safety during FY09. This included a session at the Protecting Texas Children Conference, presentations to teen mothers, elementary schools, DSHS Regional Public Health Improvement staff, and training to the Department of Family and Protective Services child welfare workers. 46 presentations serving 1,015 participants were conducted during the reporting period.

Activity 4: Local child fatality review teams (CFRT) activities included car safety seat clinics and Shattered Dreams workshops in high schools. The State CFRT committee made

recommendations in the CFRT annual report for a booster seat law for children age 4 to 8 years old and that driver education include information about injury and death from roll-overs and back-overs. The annual report is submitted to the Governor and the Texas Legislature. The State CFRT committee also released Position Statement: Motor Vehicle Safety for Infants and Children. Three sessions on child passenger safety were presented at the Protecting Texas Children Conference held in October 2008. Texas legislation was passed that requires the use of booster seats for children up to 8 years of age. CFR workshops were conducted in all eight DSHS Health Service Regions in summer 2009. Workshops included a session on "Preventing Motor Vehicle Crash Deaths" at all eight sites. A total of 443 participants were trained through these workshops.

See Attachment IV. C. NPM10 - Accomplishments for information on FY09 population-based injury prevention activities.

Performance Assessment: Trends in the data suggest a continued decline in the mortality rate due to motor vehicle crashes among children 14 years of age and younger. Though provisional, this rate was below 5.0 deaths per 1,000 children again in 2009. This decline was achieved through a combination of education and the distribution of safety seats. With the passing of recent legislation in FY09, requiring booster seats for children up to age 8, and increased collaboration between the SCFRT, local CFRTs, and the Texas Department of Transportation, the decline should continue with additional awareness and prevention activities.
An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Distribute child safety seats to low-income families via educational classes throughout the state.		X		
2. Conduct national Child Passenger Safety (CPS) technician training courses and update/renewal classes.			X	
3. Conduct traffic safety presentations throughout the state.			X	
4. Review of report on child deaths resulting from motor vehicle crashes and develop policy recommendations and activities aimed at reducing such deaths.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activity 1: 157 organizations participated in car seat distribution classes. 782 classes were held; 2,962 safety seats were distributed.

Activity 2: 6 Child Passenger Safety technician courses were held. 3 Safe Riders CPS Technician Workshops trained 45 students. 3 CPS Technician workshops trained 56 students and 3 Safe Riders Technician Renewal Classes were held training 55 students, including a teleconference course.

Activity 3: 20 child seat checkups and inspection stations were held statewide. 547 families received education and had their child safety seat restraints checked. 18 Child Passenger Safety and Safety Belt presentations were conducted. 2 presentations educated 74 individuals, and 2 presentations were made for television.

Activity 4: The State Child Fatality Review Team Committee developed several recommendations that address motor vehicle safety and risks to children in or around vehicles, including amending the Transportation Code to address the risk of using wireless devices while driving and to require drivers younger than 18 years of age cited for a moving violation must appear in court and be with a parent or legal guardian to settle the violation.

Activity 5: DSHS regional staff participated in over 20 events to issue over 200 car and booster seats and to check safety seats. They also distributed calendars and brochures on child passenger and bike safety, and worked with School Health Advisory Councils and school districts to implement driver safety programs.
An attachment is included in this section.

c. Plan for the Coming Year
Activity 1: Distribute child safety seats to low-income families via educational classes throughout the state.

Output Measure(s): Number of organizations that participate in the distribution and education program; the number of safety seats issued to participating organizations; and the number of safety seats distributed.

Monitoring: Maintain a current list of participating organizations; track the number of seats distributed to the organizations on an ongoing basis.

Activity 2: Conduct national Child Passenger Safety (CPS) technician training courses and update/renewal classes.

Output Measure(s): Number of CPS technician training courses per quarter; number of students per course; number of update/renewal classes for certified CPS technicians; number of students per update/renewal classes.

Monitoring: Track number of technician training courses (per calendar year); number of students per course; number of update/renewal classes per year; number of students per class.

Activity 3: Conduct traffic safety presentations throughout the state.

Output Measure(s): Number of traffic safety presentations conducted; number of persons attending each presentation.

Monitoring: Track progress of presentations conducted (per calendar year).

Activity 4: Review of report on child deaths resulting from motor vehicle crashes and develop policy recommendations and activities aimed at reducing such deaths.

Output Measure(s): Annual Child Fatality Review Team (CFRT) Report on child deaths that includes motor vehicle crash deaths and policy recommendations; CFRT involvement in motor vehicle safety awareness activities; training session(s) on reducing motor vehicle crash deaths and appropriate prevention strategies at CFRT Annual Conference.

Monitoring: Updates on child deaths, prevention and training activities, and potential recommendations at quarterly State CFRT Committee meetings.

Activity 5: Conduct regional motor vehicle safety activities throughout the public health regions.

Output Measure(s): Number of child safety seat check activities, number of safety seat checks conducted/number of safety seats installed; number of motor vehicle safety activities.

Monitoring: Quarterly progress reports.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		38	38.5	37	48.5
Annual Indicator	37.5	34.9	46.1	52.5	55.3
Numerator			182673	218763	235411
Denominator			396167	416533	425467
Data Source				National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	56	56.5	57	57.5	58

Notes - 2009
The CDC has changed the way they report breastfeeding data on the National Immunization Survey, which began in 2004. In the past, breastfeeding rates were reported by the year the data was collected, using children up to 3 years old. This year, they are reported by birth cohort. Now, breastfeeding histories are reported for children born in the year 2004 and are reported as the 2007 data. For the FY10 application, Texas has revised previous years estimates to produce more accurate projections for 2007, 2008, and 2009. This was unanticipated during the preparation of the 2009 application. Therefore, the targets are not reflective of this change in methodology which resulted in increased rates in Texas. We are unable to change the performance objectives for 2007, 2008, and 2009 due to data entry limitations in the TVIS system.

For 2007, 2008, and 2009, estimates are linear projections using data from the National Immunization Survey for 2002 through 2006. Denominator data are all live births. Estimates for 2007, 2008, and 2009 are based on a linear projection using natality data from 1991 through 2006. Numerator data are calculated by multiplying the percent from the National Immunization Survey and the total number of live births.

Notes - 2008
The CDC has changed the way they report breastfeeding data on the National Immunization Survey, which began in 2004. In the past, breastfeeding rates were reported by the year the data was collected, using children up to 3 years old. This year, they are reported by birth cohort. Now, breastfeeding histories are reported for children born in the year 2004 and are reported as the 2007 data. For the FY10 application, Texas has revised previous years estimates to produce more accurate projections for 2007, 2008, and 2009. This was unanticipated during the preparation of the 2009 application. Therefore, the targets are not reflective of this change in

methodology which resulted in increased rates in Texas. We are unable to change the performance objectives for 2007, 2008, and 2009 due to data entry limitations in the TVIS system.

For 2007, 2008, and 2009, estimates are linear projections using data from the National Immunization Survey for 2002 through 2006. Denominator data are all live births. Estimates for 2007, 2008, and 2009 are based on a linear projection using natality data from 1991 through 2006. Numerator data are calculated by multiplying the percent from the National Immunization Survey and the total number of live births.

Notes - 2007
Source of data is the National Immunization Survey. Numerator and denominator data are not available.

The CDC has changed how breastfeeding rates are presented from last year. Previously, results were presented by the year the mother was surveyed. Results are now presented by birth year and 2004 is the most recent year available.

Data presents a projected linear trend for 2005 through 2007 based on updated birthyear data from 2001 through 2004. The final percentages for previous years were:
Year 2001 - 38.8
Year 2002 - 38.8
Year 2003 - 35.5
Year 2004 - 37.3

a. Last Year's Accomplishments
Activity 1: Efforts to increase community access included 99,903 DSHS website hits; ongoing production of 61 education materials and promotional items (e.g. literature, forms, posters, DVDs, bags, etc.); new production of 3 booklets, 2 logos, 4 promotional materials, and the Breastmilkcounts.com website; DSHS staff attended all state breastfeeding coalition meetings; initiation of DSHS policy improvement contracts with 2 hospitals and with an organization for outreach to schools and childcare providers; and 8 stakeholder presentations. 26 new peer counselor (PC) trainers were trained (17 WIC and 9 non-WIC staff). WIC local agencies across the state trained 156 new PCs, and employed 350 PCs. Title V funding provided the Texas Breastfeeding Coalition technical support to develop a 5-year strategic plan and draft bylaws. The DSHS Breastfeeding Workgroup was formed to coordinate agency activities, including development of a DSHS-specific breastfeeding strategic plan.

Activity 2: A new report described the effectiveness of the Texas Ten Steps (TTS) program, compliance of facilities with TTS guidelines, and provided recommendations to improve and promote the program. Based on findings, an annual re-certification process was instituted. TTS hospitals were asked to re-apply. 74 (69 recertified, 5 new) hospitals were designated TTS in August 2009. 3 hospitals did not reapply. The Texas Medical Association (TMA) endorsed TTS. 4 TTS hospitals were designated as Mother-Friendly Worksites (MFW).

Activity 3: 154 DSHS trainings were held for 3,568 health care professionals. A peer-reviewed journal article was published. 1 oral and 3 poster presentations were made at the CDC MCH-Epi Conference. There were 2,696 Physician Resource website hits. Development began for an online hospital staff breastfeeding module. DSHS breastfeeding activity highlights were presented to TMA. A packet for health care providers about the new WIC food packages (including health care provider, special needs, and new foods information) and breastfeeding education materials (2 DVDs, 2 pamphlets, the CDC Maternity Practices in Infant Nutrition and Care study report, and TTS and WIC PC Programs flyers) were mailed to 23,884 physicians and hospitals. A smaller packet was mailed to 8,123 other health professionals. Development began on a targeted campaign to encourage hospital policies to support exclusive breastfeeding. A contractor was funded to examine barriers to breastfeeding support for prenatal providers, develop provider

toolkit, conduct a cost-analysis for hospitals to become Baby-Friendly, and provide findings in FY10.

Activity 4: 15 technical assistance contacts were made; 22 MFWs were designated. MFW information was presented at the Texas Breastfeeding Coalition's (TXBC) Business Stakeholder meeting in Austin, TXBC Business Case for Breastfeeding (BCFB) training for stakeholders in San Antonio, and the State Wellness Conference in Austin. Revisions began to the DSHS worksite lactation support policy using the BCFB toolkit. A committee was formed and an agency-wide needs assessment was initiated. Improved support for breastfeeding mothers was identified as a wellness priority for state agencies. Evidence-based strategies to implement worksite lactation support policies were added to the state wellness website.

Activity 5: Data were monitored and communicated during presentations, meetings, and calls. 2006 National Immunization Survey data show the proportion of mothers who breastfed ever (78%), at 6 months (49%), at 12 months (25%), exclusively at 3 months (34%) and exclusively at 6 months (14%). 2007 PRAMS data show 81% of mothers ever breastfed. 2006 birth certificate data show 75% infants were breastfed at hospital discharge. 2008 newborn screening data show 75% infants were breastfed and 41% were exclusively breastfed at 2 days. Of pregnant respondents for Texas BRFSS, 80% report intent to breastfeed. In September 2008, 68% of infants born-to-WIC initiated breastfeeding, increasing to 75% in August 2009. The 2009 WIC infant Feeding Practices Survey was administered; surveys were catalogued and scanned.

Performance Assessment: Preliminary data indicate the rate exceeds 50% for the 2nd consecutive year. New data sets and cross-program collaboration enhanced planning. Activities promoting policy and environmental changes in health care, worksites, and communities are designed to support breastfeeding initiation, continuation, and exclusivity.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Improve community access to education and support resources to promote breastfeeding.			X	
2. Assist Texas hospitals and birthing centers (birthing facilities) to become accredited through Texas Ten Steps and evaluate breastfeeding rates at hospitals that have been accredited.			X	X
3. Provide breastfeeding training and resources to health care professionals by using multiple methods, including distribution of educational materials and conducting training programs.			X	
4. Assist Texas worksites to become designated through the MFWP and provide follow-up support.			X	X
5. Monitor breastfeeding rates of mothers through the analysis of previously collected breastfeeding surveillance data (WIC annual Infant Feeding Practices Survey, PRAMS, Texas BRFSS).				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: 10 PCs and 18 PC Trainers were trained. 66 (4 new) breastfeeding materials were produced. DSHS staff participated in all local, state, and national breastfeeding coalition meetings/phone conferences. 2 new data sources were identified. Information was shared via 4 state and 1 national conferences, 4 professional meetings, 1 webinar, 2 DSHS leadership

meetings, 1 newsletter article, and 15 requests from external partners. Website data are not currently available. 2 (WIC and DSHS Infant Feeding Workgroup) breastfeeding strategic planning processes were begun. A contract (Baby Café) was executed. New WIC food packages were initiated.

Activity 2: There are 75 (1 new) TTS, 4 Baby Friendly Hospitals (BFH), and 7 BFH letters of intent. Outreach included 2 reports, 21 materials, 3 meeting presentations, 684 web site hits, and 1,707 health professionals trained. WIC hospital experience data are not yet available.

Activity 3: Progress includes 8 new applications (7 designated); legal process for changes to MFWP determined; MFWP presentation at state wellness conference given; and a $2.8 million competitive American Recovery and Reinvestment Act of 2009 grant awarded for MFWP Initiative. WIC recipient report of support in the workplace will be available in the 3rd quarter of FY10.

An attachment is included in this section.

c. Plan for the Coming Year
Activity 1: Develop promotion and support of breastfeeding in the community.

Output Measure(s): Completed community support report including indicators related to breastfeeding rates; information, communication, referrals, and outreach activities; mother-to-mother support; professional support; and infrastructure building activities.

Monitoring: Review progress toward completion of report.

Activity 2: Develop promotion and support for breastfeeding in health care systems.

Output Measure(s): Completed health services report including indicators related to birth facility support and information, education, and communication for health services.

Monitoring: Review progress toward completion of report.

Activity 3: Develop promotion and support for breastfeeding in the workplace.

Output Measure(s): Completed workplace report including indicators related to increasing support for breastfeeding in the workplace through population based activities and infrastructure building activities.

Monitoring: Review progress toward completion of report.

Activity 4: Increase integration of breastfeeding promotion and support into DSHS programs.

Output Measure(s): Number and types of activities implemented within DSHS from the DSHS Infant Feeding Strategic Plan.

Monitoring: Document progress toward implementation of strategic plan.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2005	2006	2007	2008	2009

Performance Data					
Annual Performance Objective	90	90	92	96	94
Annual Indicator	89.6	91.0	92.5	92.1	92.0
Numerator	345394	366442	379007	383596	389612
Denominator	385580	402711	409639	416508	423377
Data Source				Newborn Screening Database and Natality Data	Newborn Screening Database and Natality Data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	94	94.5	95	95	95.5

Notes - 2009
Numerator data are final. Denominator includes all births in Texas regardless of maternal state of residence. In 2007, 2008, and 2009, denominator data are estimated using a linear projection using natality data from 1996 through 2006.
.

Notes - 2008
Numerator data are final. Denominator includes all births in Texas regardless of maternal state of residence. Final natality data are available for 2005 only. In 2006, 2007, and 2008, denominator data are estimated using a linear projection using natality data from 1996 through 2005.

Notes - 2007
Source for the numerator is the Texas Department of State Health Services Newborn Hearing Screening Database. The denominator is a projection of total live births using vital statistics data from 1991 to 2005. Data from 2005 vital statistics are preliminary.

a. Last Year's Accomplishments
Activity 1: In FY09, DSHS monitored 247 facilities for adherence to the newborn hearing screening mandate. Facilities were required to maintain specific standards of conduct to be in compliance with the state. Each month, facilities out of compliance were notified via email by the contractor. DSHS contacted facilities through certified mail if the issues continued three months after initial notification. Out of the 247 facilities monitored, an average of 38 facilities were out of compliance for one month and an average of 45 were out of compliance for two months.

DSHS certified 220 birthing facilities in FY09, of which 126 (57%) were Distinguished, 28 (13%) were Standard, 40 (18%) were Provisional, and 26 (12%) were Preliminary. The state certification process provides birthing facilities with a rating based on standards of conduct. Facilities can receive one of the following ratings: Preliminary, which means the facility is going through the certification process for the first time; Provisional, which requires review of the certification standards after 6 months; Standard, which is reviewed after one year; or Distinguished, which

allows three years before renewal of certification.

Within the monitored birthing facilities, 98.4% of newborns (380,706) were screened for hearing loss prior to hospital discharge, with 96.1% (371,607) passing the screening. A total of 13,373 newborns (3.5%) required follow-up upon discharge, which includes 4,274 newborns (1.1%) who missed the screening for various circumstances along with 9,099 newborns (2.4%) who did not pass the birth screen.

In June 2009, DSHS began development of an educational curriculum for outreach and training of stakeholders throughout the spectrum of care for infants with potential and/or confirmed hearing loss. Stakeholders include prenatal care providers, birthing facilities, midwives, audiologists, medical home providers, early childhood intervention services, and ear, nose, and throat offices.

During the reporting period, DSHS presented information on the Texas Early Hearing Detection and Intervention (TEHDI) program to over 100 people including the Frew Advisory Committee (30 participants), DSHS Texas Health Steps Provider Relations staff (35 participants), Texas Deaf and Hard-of-Hearing Leadership Council (25 participants), and 3 birth facility site visits (15 participants). The TEHDI contractor provides case management in addition to training, outreach, and technical assistance to birth facilities. In FY09, TEHDI Advocates conducted 55 on-site trainings for birthing facilities and collaborating agencies.

A web-based reporting system, Provider Access, was developed specifically for primary care providers. Mailings and emails were sent out to publicize the new system and encourage its use, including a certified letter and mailer using the TEHDI branding sent to 2,500 primary care providers in Texas.

Performance Assessment: There was a continued decline in the percent of newborns receiving a hearing screen between 2008 and 2009, but the percent remained at the 92% level. Program activities, including outreach, technical assistance, and a provider web-based system are implemented to improve screening and follow-up.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Conduct monitoring of mandated newborn hearing screening programs to verify that they meet certification criteria and evaluation using the data and software system established to manage the program.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: DSHS monitored 245 facilities for adherence to the newborn hearing screening mandate; 146 were compliant and 99 were noncompliant. DSHS certified 62 birthing facilities with the following ratings: 11 were Distinguished, 21 were Standard, 9 were Provisional, and 14 were Preliminary.

Activity 2: 99% of infants born in DSHS-monitored birth facilities were screened for hearing loss prior to hospital discharge. Of these, 98% passed screening. 5,381 newborns (3%) required follow-up upon discharge, including 1,288 (1%) who missed the screening and 4,093 (2%) who did not pass the birth screen.

Activity 3: The DSHS TEHDI program exhibited at 4 conferences (5,150 participants) and presented at 8 meetings/conferences (588 participants). Approximately 116,000 TEHDI educational materials were requested and distributed.

Activity 4: 21 on-site trainings were conducted for birthing facilities throughout Texas.

A web-based reporting system, Provider Access, was created for Primary Care Providers (PCPs) to access hearing screening results and track follow-up care of newborns with suspected hearing loss. The TEHDI program performs a comprehensive outreach campaign including monthly postcards alerting PCPs of newborns referred to them. As of February 28, 2010, 171 PCPs have enrolled and 93 providers actively use Provider Access.
An attachment is included in this section.

c. Plan for the Coming Year
Activity 1: Conduct monitoring of mandated newborn hearing screening programs to verify that they meet certification criteria.

Output Measure(s): Number of compliant and noncompliant programs that report newborn hearing data to DSHS.

Monitoring: Document the results through monthly reports generated by the newborn hearing electronic monitoring system developed for this project.

Activity 2: Evaluation of the TEHDI program utilizing system data to manage the program.

Output Measure(s): Number and percent of infants screened before hospital discharge, number and percent of infants who do not pass the birth screen, number and percent of infants who did not receive a birth screen and number and percent of infants requiring follow-up.

Monitoring: Review of system data utilizing quarterly reports generated by the hearing management information system.

Activity 3: Collaborate with multiple stakeholders to develop and disseminate educational materials for providers and parents.

Output Measure(s): Number and type of stakeholders involved in activities, type and number of materials developed and disseminated, number of stakeholder meetings held.

Monitoring: Documentation of meetings held and number of educational materials distributed; review Texas Health Steps Continuing Education module completion records.

Activity 4: Provide training, outreach, and technical assistance to hospitals and medical home providers.

Output Measure(s): Type and number of trainings delivered; number of new providers utilizing the hearing management information system and technical assistance provided.

Monitoring: Review of the quarterly reports generated by the electronic hearing management information system and other TEHDI databases developed.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	20	20	19.9	20	20
Annual Indicator	18.9	18.9	21.4	17.9	19.5
Numerator	1224279	1224279	1434980	1216968	1345378
Denominator	6476859	6476859	6720386	6783441	6887506
Data Source				US Census Bureau, Current Population Survey	US Census Bureau, Current Population Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	19.5	19.5	19	19	18.5

Notes - 2009
Data in 2005 and 2006 are duplicated. This was due to a data entry error in the previous grant submission. In this previous submission, 2006 data were entered in the 2005 column. Data presented in the columns for 2006, 2007, and 2008 are correct and final. 2009 data is a linear projection based on data from 2003-2008. Numerator and denominator data are provided by the US Census Bureau, Current Population Survey, Annual Social and Economic Supplement (http://www.census.gov/hhes/www/cpstc/cps_table_creator.html).

Notes - 2008
Data in 2005 and 2006 are duplicated. This was due to a data entry error in the previous grant submission. In this previous submission, 2006 data were entered in the 2005 column. Data presented in the columns for 2006, 2007, 2008, and 2009 are correct and final. Numerator and denominator data are provided by the US Census Bureau, Current Population Survey, Annual Social and Economic Supplement (http://www.census.gov/hhes/www/cpstc/cps_table_creator.html).

Notes - 2007
Data in 2005 and 2006 are duplicated. This was due to a data entry error in the previous grant submission. In this previous submission, 2006 data were entered in the 2005 column. Data presented in the columns for 2006, 2007, 2008, and 2009 are correct and final. Numerator and denominator data are provided by the US Census Bureau, Current Population Survey, Annual

Social and Economic Supplement
(http://www.census.gov/hhes/www/cpstc/cps_table_creator.html).

a. Last Year's Accomplishments
Activity 1: According to estimates provided through the U.S. Census Bureau's Current Population Survey, Annual Social and Economic Supplement, 2009, there were 6,783,441 children under the age of 18 residing in Texas. Of these children, 1,216,968 (17.9%) did not have health insurance coverage.

Activity 2: Title V-funded prenatal care and health and dental services for children continue to be provided through fee-for-service contractors who are required to screen and refer all clients for Medicaid and CHIP. In FY09, there were 35,459 individuals under the age of 21 served by Title V-funded contractors throughout the state.

Performance Assessment: Texas continues to lead the nation in uninsured children with approximately one-fifth of all children living without health insurance. Despite the fact that the number of children served by Title V-funded prenatal care and child health and dental services increased from 2008-2009, the percent of children and adolescents with no coverage has increased. Increased outreach and education efforts have been implemented to help ensure that available public assistance programs (Medicaid and CHIP) are maximized by insuring as many eligible children as possible. These efforts will continue and Title V staff will continue to seek opportunities to support these efforts.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitor and report the percentage of children without health insurance.				X
2. Screen all children at Title V-funded clinics for potential CHIP (including the CHIP perinatal benefit) and Medicaid eligibility and make referrals to appropriate programs.			X	X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activity 1: Estimates are developed from various sources for calendar years. There are no updates for this activity until the end of FY10.

Activity 2: Title V-funded prenatal care and health and dental services for children and adolescents continue to be provided through fee-for-service contractors who are required to screen and refer all clients for Medicaid and CHIP. As of March 29, 2010, data showed 8,916 children were enrolled into the CHIP perinatal benefit plan; 7,451 children were enrolled in CHIP; and 4,308 children were enrolled into the dental program.

An attachment is included in this section.

c. Plan for the Coming Year
Activity 1: Monitor and report the percentage of children without health insurance.

Output Measure(s): Percent of children without health insurance.

Monitoring: Follow progress in developing periodic child health insurance status report.

Activity 2: Screen all children at Title V-funded clinics for potential CHIP (including the new CHIP perinatal benefit) and Medicaid eligibility and make referrals to appropriate programs.

Output Measure(s): Percentage of children without health insurance who are enrolled into CHIP and other state-funded insurance programs as identified by Title V contractors.

Monitoring: Periodic quality assurance reviews of contractors.

Activity 3: Identify and develop partnerships with internal and external stakeholders to increase children's access to insurance.

Output Measure(s): Number and types of partnerships and trainings, activities, and resources developed/distributed; summary report on collaborative efforts undertaken.

Monitoring: Track the number and type of partnerships, trainings, and activities; documentation of materials created and/or distributed; review of Health Service Region reports.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		23	22	21	23
Annual Indicator	23.7	23.9	24.1	31.5	31.7
Numerator	162380	160793	164231	146631	139500
Denominator	683968	671445	680571	465319	439390
Data Source				WIC Program Data	WIC Program Data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	29	28.5	28	27.5	27

Notes - 2009
Data for 2005, 2006 and 2007 are for children ages one to five years of age. This was due to an error in the code used to create the tables. Data for 2008 and 2009 are correct. The targets for 2008 and 2009 are not reflective of this error.

Denominator data are all children ages two to five years of age. These data are reported through certification data provided by the WIC program. Numerator data are all children with a BMI at or above the 85th percentile as noted in the Health and Nutrition Risk Tables provided by the WIC program.

Notes - 2008
Data for 2005, 2006 and 2007 are for children ages one to five years of age. This was due to an error in the code used to create the tables. Data for 2008 and 2009 are correct. The targets for 2008 and 2009 are not reflective of this error.

Denominator data are all children ages two to five years of age. These data are reported through certification data provided by the WIC program. Numerator data are all children with a BMI at or above the 85th percentile as noted in the Health and Nutrition Risk Tables provided by the WIC program.

Notes - 2007
Source: WIC Database, Office of Title V and Family Health

a. Last Year's Accomplishments
Activity 1: 461,127 of the 497,204 women enrolled in the Special Supplemental Nutrition Program (WIC) (92.7%) received nutrition education. 1,216,895 of the 1,332,702 total WIC population (women and children) enrolled (91.3%) received nutrition education. The DSHS WIC program funded special obesity prevention projects at 35 different local WIC agencies. Additionally, the WIC program allocated funding to 69 local agencies with a total caseload of approximately 727,000 participants to pay for the services of contract registered dietitians (RDs) or defray the salary of staff RDs. RDs provided high risk counseling, conducted quality assurance self audits, provided staff training on nutrition related topics, and participated in other special projects such as obesity prevention.

Activity 2: Reports for two focus group/key informant interview studies related to WIC family food consumption patterns were completed. One study evaluated nutrition practices in licensed childcare facilities. Differences in nutrition practices between home-based and center-based childcare facilities as well as between independent and corporately managed facilities were observed. The survey that examined attitudes of WIC recipients toward the new WIC food package was completed and the new WIC food package was implemented. A total of 6,733 questionnaires were received. The survey will be repeated in fall 2010 to look at post-implementation attitudes and behavior changes based on the new WIC food package. The 2009 WIC Infant Feeding Practices Survey, a convenience sample of mothers entering a WIC clinic for certification of their one-year old child anytime from April 15-July 31, 2009, was administered prior to the rollout of the Every Ounce Counts breastfeeding media campaign and the new WIC food packages. Surveys were administered at WIC local agencies across the state, and a total of 6,795 surveys were returned, logged, and forwarded for scanning and coding of data.

Performance Assessment: A childhood obesity treatment program was implemented in FY09 targeting children aged 2-12 in the 85% or greater for BMI. Increased analysis of WIC data, including data on the October 2009 WIC food package changes, may also yield new ways for intervention or improved targeting. A continued and expanded focus on breastfeeding throughout DSHS may contribute to future reductions in childhood obesity.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Promote and support activities to reduce obesity among WIC children ages 2 to 5 years.			X	

2. Study food consumption patterns in WIC families.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: 336,897 of the 383,329 enrolled women (87.9%) and 1,159,243 of the 1,414,869 total WIC-enrolled women and children (81.9%) received nutrition education. $453,000 has been dispersed to 31 WIC local agencies as FY10 Obesity Prevention Mini Grants for special education initiatives that target obesity in the WIC population. A total of $1,184,870 has been dispersed to 63 WIC local agencies to contract RD services or to defray staff RD salaries. WIC program data indicate that, of infants born-to-WIC, 75.7% initiated breastfeeding in the hospital.

Activity 2: 1,000 FY09 WIC Wellness Works post surveys from participants are being prepared for data analysis. To date, 216 FY10 pre-surveys have been received. The Staff Food and Nutrition (STAFAN) survey was re-administered to all WIC Local Agencies in February 2010 by Texas A&M. As of mid-March 2010, 1,000 STAFAN surveys have been received from the field. About 6,800 WIC participant food consumption survey responses were used to provide state and local agency-level reports about consumption patterns before the food package changes. Baseline local and state reports from the Texas Food and Nutrition Survey (TEXFAN) have been posted online.

Data for the 2009 WIC Infant Feeding Practices Survey were analyzed, with 5,427 surveys completed by biological mothers enrolled in WIC during pregnancy. A state, regional, and WIC Local Agency report will be prepared in the 3rd quarter of FY10. The survey is administered every 2 years.

An attachment is included in this section.

c. Plan for the Coming Year

Activity 1: Promote and support activities to reduce obesity among WIC children ages 2 to 5 years.

Output Measure(s): Number of WIC participants receiving nutrition education at time of benefit issuance; type and number of activities included; funding of WIC obesity projects; funding registered dietitians at clinics to engage children at risk for obesity; number of new mothers who choose to breastfeed.

Monitoring: Review quarterly WIC performance measure data on nutrition education contacts.

Activity 2: Study food consumption patterns in WIC families.

Output Measure(s): Number of surveys and studies conducted to determine food consumption patterns. Reports and presentations of findings.

Monitoring: Track quarterly progress on studies and analyses.

Activity 3: Identify factors that affect the redemption rate for WIC participants and the length of time participants remain on the WIC program.

Output Measure(s): Type and number of activities included; summary report on factors identified.

Monitoring: Track progress on activities and review report.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		7.3	7.2	7.5	8
Annual Indicator	7.4	7.9	8.3	8.2	8.3
Numerator			32882	34045	35188
Denominator			396167	416533	425467
Data Source				PRAMS and Natality Data	PRAMS and Natality Data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	8	7.5	7.5	7	7

Notes - 2009
PRAMS data for Texas are only available through 2007. The estimate for 2008 and 2009 is a linear projection based on PRAMS data from 2002 through 2007. Denominator data are all live births. Birth estimates for 2007, 2008, and 2009 are based on a linear projection using natality data from 1991 through 2006. Numerator data are calculated by multiplying the percent from PRAMS and the total number of live births.

Notes - 2008
PRAMS data for Texas are only available through 2007. The estimate for 2008 and 2009 is a linear projection based on PRAMS data from 2002 through 2007. Denominator data are all live births. Birth estimates for 2007, 2008, and 2009 are based on a linear projection using natality data from 1991 through 2006. Numerator data are calculated by multiplying the percent from PRAMS and the total number of live births.

Notes - 2007
Note that provisional data were updated in the FY08 annual report.

Source: Data presents a linear trend based on PRAMS data from 2002 through 2006. Years prior to 2006 could not be updated due to TVIS limitations. The final percentages for previous years are as follows:
Year 2004 - 6.9
Year 2005 - 8.3

a. Last Year's Accomplishments
Activity 1: A fact sheet was developed. Four collaborative planning meetings with the Department of Family and Protective Services were held in FY09 for development of a safe sleep

campaign. Health promotion messages and materials targeted to pregnant and parenting women and their families were developed. As a result of the collaborative efforts in creating the fact sheet, an intra-agency work group was formed to address infant health. Current projects focus on safe sleep and sudden infant death syndrome (SIDS) prevention. In addition to the fact sheet, a training targeting parents and caregivers is being developed for use by professionals, lay health workers, and community groups to educate parents about safe sleep. The work group is also in the process of contracting for the development of safe sleep training for Child Protective Services (CPS) caseworkers. This training will be mandatory and will provide CPS caseworkers with tools to evaluate sleep environments of families they are involved with that have infants. Both trainings will address the role of secondhand smoke in SIDS prevention.

Activity 2: Tobacco cessation brochures (n=250) targeting pregnant women and re-ordering information were distributed to attendees at the Texas Healthy Start Alliance conference. A meeting was held with the DSHS Community Health Worker/Promotora Program to discuss strategies for delivering tobacco cessation training to promotoras. A meeting was held with the DSHS Tobacco Prevention and Control Program to discuss the possibility of developing or adapting a tobacco cessation curriculum to provide continuing education to promotores based on the program's "Yes You Can" Clinical Toolkit for Treating Tobacco Dependence. The training designed for community coalitions was not readily adaptable for promotores, but plans were developed to create or adapt a suitable alternative in FY10.

Activity 3: 2007 PRAMS data indicate smoking the last 3 months of pregnancy was 8.3% overall. The rate was lowest among Hispanics (3.3%), followed by African Americans (8.3%), and White or Other (14.8%). 2006 birth certificate data indicate that 4.2% of women giving birth smoked during the third trimester. The rate was lowest among Hispanics (1%), followed by African Americans (4.2%), and Whites (9.2%). The rate for other races/ethnicities was 1.5%. Smoking rates in the third trimester were higher (4.5%) for women aged 19 and younger than in women aged 20 and older (4.2%). Production of a report of data findings and referral resources was completed FY09.

Performance Assessment: Rates of smoking in the third trimester remained about the same between 2007 and 2009. The nature of tobacco addiction may be a factor in this indicator. Efforts to impact this measure are currently underway, including media campaigns and expanding capacity to provide brief interventions for pregnant women. Collaborating with non-traditional partners and continued emphasis on locally driven strategies may aid in future progress in this measure.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Develop SIDS prevention fact sheet that addresses secondhand smoke in conjunction with Texas Department of Family and Protective Services.			X	
2. Coordinate with peer counselors/community health workers program to provide information regarding smoking cessation during pregnancy.			X	
3. Monitor smoking rates of smoking in the last three months of pregnancy among adults and teens by race and ethnicity and to identify co-factors using birth record data and PRAMS.				X
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities
Activity 1: No paid media was used during the 2nd quarter, however the DSHS Tobacco Prevention and Control Program began to distribute Yes You Can TV commercials as public service announcements (PSAs) throughout the state's TV markets. Through February 2010, a total of 1,686 PSAs ran in seven Texas markets (Austin, Beaumont/Port Arthur, Corpus Christi, Dallas, El Paso, Houston, San Antonio) a total of 1,686 times producing 2,754 gross ratings points at a value of $348,470.

Activity 2: According to 2007 PRAMS data, 8.3% of pregnant women smoked in their last three months of pregnancy. The incidence was highest in White women, at 14.8%, and lowest for Hispanic women at 3.3%. Also, women whose income was less than $15,000 per year were much more likely to smoke in the last three months of pregnancy (13.4%) versus women who made more than $50,000 per year (4.1%).

Activity 3: A meeting was held in the first quarter to discuss the development of a training for promotores/community health workers regarding tobacco cessation during pregnancy. Discussion about training certification and working with a local training agency to pilot the training helped to shape the direction of the project. In the second quarter, a training outline was developed and reviewed by Title V MCH staff. Module development will begin in the 3rd quarter.
An attachment is included in this section.

c. Plan for the Coming Year
Activity 1: Implement tobacco cessation social marketing campaign targeting pregnant women and expectant fathers.

Output Measure(s): Total number of media spots; report detailing campaign impact; number of PSA DVDs ordered by hospitals and clinics for display on close circuit TVs; number of calls to Quitline resulting from campaign; number of web hits to campaign microsite; other activities that promote tobacco cessation.

Monitoring: Track campaign progress and development of report; review quarterly Health Service Region reports.

Activity 2: Monitor smoking rates in the last three months of pregnancy among adults and teens by race and ethnicity.

Output Measure(s): Written review of data, data review communicated to external stakeholders including March of Dimes, Healthy Start, WIC, and Title V fee-for-service and population-based providers; information on website, including referral resources for providers and clients.

Monitoring: Review birth record, PRAMS, and Texas BRFSS data as available.

Activity 3: Develop and implement training for promotores/community health workers to provide smoking cessation interventions during pregnancy.

Output Measure(s): Training module developed and disseminated to approved organizations providing DSHS certified continuing education for promotores/community health workers; number of DSHS approved training programs adding the module to their approved curriculum; number of continuing education programs using the module held by DSHS approved training programs and number of participants trained.

Monitoring: Track development of module at regular work group meetings; track implementation of module through regular contact with the training programs and reports available on request.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	9	7.8	7.6	6	5.5
Annual Indicator	8.0	6.9	6.4	5.8	5.4
Numerator	141	125	118	108	98
Denominator	1756503	1810309	1840936	1866100	1829806
Data Source				Mortality Data and Office of the State Demographer	Mortality Data and Office of the State Demographer
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	5.2	5.2	5	5	4.8

Notes - 2009
All mortality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1999 through 2006.
Denominator data provided by the Office of the State Demographer.

Notes - 2008
All mortality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1999 through 2006.
Denominator data provided by the Office of the State Demographer.

Notes - 2007
All mortality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1999 through 2006.
Denominator data provided by the Office of the State Demographer.

a. Last Year's Accomplishments
Activity 1: The Education Service Centers have conducted 51 gatekeeper trainings to 1,534 people. Over 36,000 brochures and materials on Question, Persuade, and Respond (QPR) were

distributed through 102 workshops, exhibits, conferences, meetings, community presentations, and to QPR instructors. 34 workshops and 7 exhibits were held around the state about suicide prevention. Additionally, 13,378 suicide prevention bookmarks and other suicide prevention handouts were distributed at 28 conferences, meetings, mailings, and trainings. There were 17 media events including 3 news releases, 5 news coverage events, 1 newsletter, 2 radio interviews, 2 television events, 4 web-related events, and 36 meetings and consultations across the state.

The 81st Texas Legislature (2009) enacted House Bill 1067, which allows for timely sharing of data from Medical Examiner's offices with local Mental Health and Mental Retardation centers and other community agencies in order to stop suicide contagions or clusters. Work continues in the development of memorandums of understanding among Local Mental Health Authorities and other community agencies for the sharing of data on suicides.

Over $50,000 was secured in sustainable funds for the Teen Suicide Prevention Network. During FY09, a proposal was approved to develop an online suicide prevention training program for Texas high schools. Due to the availability of sustainable funding, a decision was made to provide funding for the Texas High School Suicide Prevention Online Training Program through FY10. In April 2009, DSHS applied for renewal funding for the Texas Youth Suicide Prevention (TYSP) grant as it operated in FY09 on a no-cost extension with unspent funds from previous years. Funding renewal is anticipated at $500,000 per year for a three year period.

Activity 2: These contracts concluded and funding was discontinued in FY08.

Activity 3: Suicide death data were analyzed and included in the 2008 Child Fatality Review Annual Report. Dr. Lloyd Potter presented on suicide prevention at the Protecting Texas Children annual conference. Child Fatality Review Team (CFRT) recommendations included increased mental health services in rural areas. The State CFRT formed a workgroup to draft a Position Statement on youth suicide prevention. Child Fatality Review workshops were conducted in all 8 health service regions (HSRs) in summer 2009; training included "Preventing Youth Suicide" at all 8 sites with a total of 443 receiving the training. As a result of the training in each of the DSHS HSRs, 3 communities, Amarillo, Edinburg, and Tyler, held follow-up meetings to discuss opportunities for forming new community-based suicide prevention coalitions.

Activity 4: Texas Adolescent Mental Health in Primary Care Initiative partners were not convened in FY09. This project has concluded.

Performance Assessment: Suicide rates among youth ages 15 to 19 years continue to decline below the FY09 target. Continued attention to this topic through the CFRTs' activities, the formation of new local suicide prevention activities, and increased opportunities to educate teachers and other school personnel on identifying signs and symptoms of suicide may contribute to the increased declines.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide support to the internal and external stakeholder workgroups addressing suicide prevention.				X
2. Provide support to the Community Mental Health Suicide Prevention (CMHP) projects Friends for Life CMHP and El Centro de Corazon.				X
3. Report on suicide deaths of 15 to 17-year-olds and develop policy recommendations aimed at prevention.				X
4. Convene the TAMHPCI partners to plan and implement the next steps in the further study of integrating mental health into				X

primary care settings.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activity 1: DSHS continued working with 3 key partners, the Center for Health Care Services (CHCS), Mental Health America of Texas (MHAT) with the Texas Suicide Prevention Council (TSPC), and Redstone Analytics, to implement the TYSP project in Texas with oversight by DSHS. MHAT continued public awareness and capacity building grant activities, including the collection of data and for a cross site evaluation. Several HSRs currently participate in, or are developing, a Suicide Prevention Coalition (SPC). The Texas Panhandle SPC in HSR 1 developed mission and vision statements. HSR staff share literature and resources on bullying and suicide prevention with School Health Advisory Councils and school districts.

Activity 2: 16 suicide prevention workshops or awareness presentations were provided through the Education Service Centers in the first half of FY10. 461 professionals received Gate Keeper training or were provided educational materials on suicide prevention. School district staff, HSR staff, and others were among those receiving the information.

Activity 3: The Colorado/Austin/Waller Counties CFRT worked with all school nurses in their 3-county area to distribute suicide prevention cards. These small cards show on one side how to respond to a friend displaying signs of being suicidal, and, on the other side, how to seek help if you are feeling suicidal. These were distributed throughout the districts in this team's geographic area.
An attachment is included in this section.

c. Plan for the Coming Year
Activity 1: Broaden the public's awareness of youth suicide, its risk factors, and prevention.

Output Measure(s): Establish website for suicide prevention information and resources; number of public awareness activities implemented through the Garrett Lee Smith Texas Youth Suicide Prevention (TYSP) Grant.

Monitoring: Document updates for the website regarding suicide information and prevention; document public awareness activities conducted as part of the TYSP Grant.

Activity 2: Provide training to individuals, communities, and schools to identify and refer youth at higher risk of suicide and suicide attempts.

Output Measure(s): Number of individuals, communities and school personnel trained in QPR (Question, Persuade, Refer) and/or ASK (Ask about suicide, Seek more information, Know how and where to refer); number of high school personnel trained in At-Risk (At-Risk is an interactive, web-based training simulation to teach school staff to effectively identify, approach, and refer students At-Risk of suicide or suicide attempts).

Monitoring: Documentation of QPR, ASK, and At-Risk trainings completed.

Activity 3: Provide support to internal and external stakeholders addressing suicide prevention.

Output Measure(s): Participate in the Texas Suicide Prevention Council; obtain information about the Suicide Prevention Coalitions established statewide; number of regional activities.

Monitoring: Review meeting notes from the Texas Suicide Prevention Council; document suicide prevention activities implemented by the Council; track the contact information of the Suicide Prevention Coalitions; document local suicide prevention activities; review quarterly Health Service Region staff reports.

Activity 4: Report on suicide deaths of 15-17 year olds and CFRT activities to promote suicide prevention.

Output Measure(s): Public awareness/educational materials developed; suicide deaths of youth 17 and younger reported in the State Child Fatality Review Team (CFRT) Committee annual report; number of trainings on developing suicide prevention initiatives presented to CFRTs; and number of local initiatives developed by or participated in by CFRTs.

Monitoring: Track materials that are developed; provide updates of youth aged 17 and younger suicide deaths and local CFRT training and suicide prevention activities at quarterly State Committee meetings.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	55	55	55	52	52
Annual Indicator	48.5	49.4	48.2	47.8	47.5
Numerator	2742	2786	2849	2908	2967
Denominator	5651	5639	5913	6079	6245
Data Source				Annual Hospital Survey and Natality Data	Annual Hospital Survey and Natality Data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	52	52.5	52.5	53	53

Notes - 2009
Using the Annual Hospital Survey from the Texas Center for Health Statistics, high risk hospitals are identified. A variable is created in the natality file to differentiate high risk hospitals from all others. All natality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1996 through 2006.

Notes - 2008
Using the Annual Hospital Survey from the Texas Center for Health Statistics, high risk hospitals are identified. A variable is created in the natality file to differentiate high risk hospitals from all others. All natality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1996 through 2006.

Notes - 2007
Using the Annual Hospital Survey from the Texas Center for Health Statistics, high risk hospitals are identified. A variable is created in the natality file to differentiate high risk hospitals from all others. All natality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1996 through 2006.

a. Last Year's Accomplishments
Activity 1: Research staff collaborated with Geographic Information Systems (GIS) staff in the Texas Center for Health Statistics to geocode all hospitals. Data from the annual American Hospital Survey, where hospitals self-designate their level of obstetric care as level I, II, or III, was obtained for the years 1999-2004. These hospital level data were merged into individual datasets of live births and fetal deaths from 1999 to 2004. A study was conducted to identify maternal socio-demographic factors associated with delivery in a level III obstetric facility. Median household income, as well as other socioeconomic indicators from the census, were merged into the dataset at the census tract level. Results of the study showed that slightly more than half (50.6%) of these births and fetal deaths occurred in a level III facility; however, greater proportions of Black women (55.2%) accessed sub-specialty care, compared to 50.5% of White women and 48.7% of Hispanic women ($p<0.0001$). These differences persisted when adjusting for degree of urbanization of mother's place of residence. Only 9.0% of births were transferred prior to delivery and this differed by race with 44.6% of White, 22.3% of Black, and 30.8% of Hispanic mothers transferred prior to delivery ($p<0.0001$). In addition to the barrier in access for Black women, there was also a geographic barrier. Women who lived farther away from a Level III hospital and had a very low birth weight (VLBW) baby were less likely to access the level of care needed. An abstract reporting these analyses was accepted for oral presentation at the 2009 MCH-Epidemiology Conference.

Activity 2: Initial analyses to identify factors associated with being seen in high- risk facilities included analysis of the number and proportion of all high-risk mothers transferred prior to delivery as well as the number and proportion of infants transferred after delivery. Maternal socio-demographic factors associated with transfer before and after delivery were completed. Initial work in obtaining stakeholder input has begun. In FY09, communication about the project was initiated with a March of Dimes subcommittee working on quality improvement initiatives related to perinatal health outcomes in Texas (the Big 5 Texas Workgroup). The Texas workgroup for this initiative met twice in FY09.

Activity 3: Commencement of this activity is contingent on completion of Activities 1 and 2. A timeline for all activities was developed in the second quarter to track progress toward completion. Activity 1 is complete, and preliminary work on Activity 2 has begun.

Performance Assessment: Less than half of all deliveries of VLBW infants occurred at facilities for high-risk deliveries and neonates. Previous research indicates the necessity for collaboration with external stakeholders in order to further impact this measure. Future efforts will center around building such collaboration and exploring the definition and standardization of level III hospitals in Texas.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide an analysis of barriers to delivery in high risk facilities for high risk mothers using birth record data, data from the Hospital Survey Unit, and Geographic Information Systems (GIS) technology.				X
2. Develop a process to facilitate appropriate referrals for at-risk clients to facilities for high-risk deliveries and neonates and				X

ensure the continued assessment of perinatal care facilities as basic, specialty or subspecialty by using GIS maps, rece				
3. Develop a letter to hospitals and other stakeholders that includes high risk perinatal care facilities as well as regional maps of their locations.				X
4.				
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b. Current Activities

Activity 1: At the MCH-Epidemiology conference in December 2009, discussion and dialogue was started with the key players in other states and at CDC who are studying utilization of level III facilities for high risk deliveries. It was determined that although the American Hospital Association Annual Survey of Hospitals collects information on obstetric level, the Division of Reproductive Health at CDC uses the neonatal level of care to measure the percent of VLBWs born in high risk facilities. Texas will begin exploring additional ways to obtain neonatal level of care information.

Activity 2: Stakeholder involvement has begun. While Texas does not currently regulate or license hospitals for their obstetric or neonatal levels of care, it may be helpful to work with similar stakeholders such as the Texas Hospital Association and the DSHS Division for Regulatory Services.

Activity 3: Staff has begun exploring which stakeholders DSHS should work with to determine a definition for level of care in Texas. The stakeholders will be approached and asked to participate in the effort as a leadership group for Texas. This includes hospital and medical associations.
An attachment is included in this section.

c. Plan for the Coming Year

Activity 1: Develop partnerships with internal and external stakeholders (e.g. DSHS Division for Regulatory Services, Texas Hospital Association) to explore standardization of neonatal level of care designations.

Output Measure(s): Number and type of contacts with internal and external partners regarding the standardization.

Monitoring: Document communication.

Activity 2: Define and map location of level III neonatal hospitals in Texas using hospital obstetric level self-designation status data, presence of a neonatal intensive care unit (NICU), number of NICU beds, and other criteria from the American Hospital Association (AHA) annual survey of hospitals.

Output Measure(s): Definition of a level III neonatal hospital in Texas; geocoded map of level III neonatal hospital locations.

Monitoring: Document communication.

Activity 3: Monitor rate of very low birth weight (VLBW) infants delivered at facilities for high-risk deliveries and neonates through the analysis of birth record data.

Output Measure(s): Number and proportion of VLBW infants delivered at level III hospitals; number and percent of high-risk women transferred prior to delivery; number and percent of infants transferred within 24 hours after birth.

Monitoring: Document the rate of VLBW infants delivered at facilities for high-risk deliveries and neonates using data from the annual AHA survey and birth record.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	85	85	85	73	74
Annual Indicator	71.3	65.4	62.6	63.5	64.4
Numerator	274856	255429	249155	256356	263765
Denominator	385580	390702	398319	403974	409630
Data Source				Natality Data	Natality Data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	66	66.5	67	67.5	68

Notes - 2009
In 2005, Texas implemented the U.S. Certificate of Live Birth, 2003. This change had a significant impact on measure of prenatal care utilization and precluded the use of a linear projection. Average annual increase was calculated (2.89%) and applied to 2007, 2008, and 2009.

Notes - 2008
In 2005, Texas implemented the U.S. Certificate of Live Birth, 2003. This change had a significant impact on measure of prenatal care utilization and precluded the use of a linear projection. Average annual increase was calculated (2.89%) and applied to 2007, 2008, and 2009.

Notes - 2007
In 2005, Texas implemented the U.S. Certificate of Live Birth, 2003. This change had a significant impact on measure of prenatal care utilization and precluded the use of a linear projection. Average annual increase was calculated (2.89%) and applied to 2007, 2008, and 2009.

a. Last Year's Accomplishments
Activity 1: Based on 2006 birth certificate data, 242,157 women, or 60.6% engaged in prenatal care in the first trimester. 106,383 women or 26.6%, engaged in prenatal care in the second trimester. For 2005, the percentage of women who engaged in prenatal care in the first trimester

was 63.0%. The change in this number from the mid-year report is due to the fact that the mid-year report was based on the most recent final birth record file that was available. This revised number is based on final 2006 birth record data.

Activity 2: DSHS regional staff assisted pregnant women in completing applications to the CHIP Perinatal Program and Medicaid. Information was not available on the number of pregnant women referred for each program. The data collection system for regional population-based activities has been revised for FY10 to align more closely with the FY10 Activity Plan.

Performance Assessment: The percent of women receiving prenatal care in the first trimester slightly increased between 2007 and 2009. Title V continues to be a safety net for prenatal care, along with Medicaid and the CHIP Perinatal program. Regional staff works to ensure that women eligible for these services are enrolled. A focus on preconception care has the potential to further impact this measure because of the emphasis on planned pregnancies and early care.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Increase awareness of the need for early prenatal care among women in the preconception period.			X	
2. Health Service Regions develop a population-based activity to ensure referral to the CHIP Perinatal Program and Medicaid.			X	
3.				
4.				
5.				
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b. Current Activities

Activity 1: Staff applied for a CDC Prevention Specialist to develop a strategic plan on preconception health. The position was not funded and the staff explored other ways to address preconception health and early prenatal care. Staff was invited to attend a Healthy Start Interconception meeting to begin work on addressing interconception care.

Regional staff continued to provide referrals for health care and social services to pregnant women through clinics, health fairs, and Healthy Start sites. HSR 1 led the Healthy Baby Coalition, a regional effort to increase the number of community health workers providing outreach to promote prenatal care and healthy birth outcomes in the region. WIC implemented a project with the Tarrant County Public Health Department to address improved birth outcomes through the use of promotores/community health workers.

Activity 2: Staff worked with Healthy Start sites to collect and analyze data, on prenatal care, perinatal depression, and demographics. Technical assistance meetings were held in October, November, and December with sites to discuss data collection and secure transfer. Data was due to DSHS in late January and analysis will occur in the second half of FY10.

Staff worked with HSR 2/3 staff to discuss prenatal care access in the region. Data requests were submitted in November and February and staff continues to provide technical assistance.

An attachment is included in this section.

c. Plan for the Coming Year
Activity 1: Increase infrastructure for improving access to prenatal care.

Output Measure(s): Number and type of strategies to increase infrastructure for improving access to prenatal care, including regional activities; number of women receiving prenatal care through Title V contractors.

Monitoring: Document strategies.

Activity 2: Monitor percent of infants born to women who received early and adequate prenatal care through the analysis of previously collected surveillance data.

Output Measure(s): Percent of infants born to women who received early and adequate prenatal care.

Monitoring: Review birth record and PRAMS data.

Activity 3: Increase DSHS engagement in preconception and interconception health.

Output Measure(s): Number of partners and initiatives DSHS participates in pertaining to preconception and interconception health.

Monitoring: Document efforts with partners and document initiatives DSHS is involved with pertaining to preconception and interconception health.

D. State Performance Measures

State Performance Measure 1: *Change in percentage of CSHCN living in congregate care settings as percent of base year 2003*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		95	90	90	85
Annual Indicator	99.3	100.1	99.4	100.4	97.8
Numerator	1606	1619	1608	1624	1582
Denominator	1617	1617	1617	1617	1617
Data Source				Permanency Planning and Family Based Alt. Report	Permanency Planning and Family Based Alt. Report
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	85	80	80	80	

Notes - 2009

Texas Health and Human Services Commission, Permanency Planning and Family Based Alternative Report- submitted to the Governor and Legislature February 2010.

The FY09 number decreased from the base year 2003. While the total number of children in institutions as defined by SB 368 has remained fairly steady, the residential settings are continuing the shift to smaller, less restrictive environments. The number of children in Intermediate Care Facilities/Mental Retardation remained steady with slight decreases in other facility types.

Notes - 2008
Texas Health and Human Services Commission, Permanency Planning and Family Based Alternative Report- submitted to the Governor and Legislature December 2008.

The FY08 number exceeds the base year 2003. While the total number of children in institutions as defined by SB368 has remained fairly steady, the residential settings are continuing the shift to smaller, less restrictive environments with two exceptions. The number of children in state mental retardation facilities, including state schools is increasing and the number of children in Department of Family and Protective Services (DFPS) is increasing.

Notes - 2007
Texas Health and Human Services Commission, Permanency Planning and Family Based Alternative Report- submitted to the Governor and Legislature December 2008.

a. Last Year's Accomplishments
Activity 1: CSHCN SP contractors provided permanency planning services for 1,411 CSHCN and their families. CSHCN SP contracted with EveryChild, Inc. to review permanency plans for children residing in certain congregate care settings and to identify reasons for continued placement and supports needed for children to successfully live in the community. The Health and Human Services Commission's (HHSC) Senate Bill (SB) 368 Permanency Planning Report noted that 1,613 children resided in institutions as of February 28, 2009. Of these, 719 children were recommended for transition to the community but had not yet transitioned. During this period, 175 children moved to less restrictive environments (other than family-based settings) and 133 children moved to family-based settings. Residential settings for children continued to shift to smaller, less restrictive environments.

Activity 2: Contractors provided family support services (FSS) for over 1,400 CSHCN and their families. CSHCN SP provided $133,412 in fee-for-service FSS benefits, including respite, van and home modifications, and other FSS. CSHCN SP provided training for regional staff and contractors to assist families in accessing FSS.

Activity 3: CSHCN SP staff assisted with the Texas Council on Developmental Disabilities Biennial Disability Report and Public Policy Priorities. Both reports supported closing or reducing the number of individuals residing in state schools. Texas' Money Follows the Person (MFP) Voluntary Closure Program resulted in closing 1 large Intermediate Care Facility (ICF). DSHS and HHSC collaborated to obtain federal approval for the Youth Empowerment Services (YES) Medicaid waiver pilot for children up to age 19 with severe emotional disturbance (SED). Beginning in FY10, the waiver will provide community-based services and supports for children with SED to prevent inpatient admissions and reduce out-of-home placements.

The Texas Legislature funded exceptional items supporting CYSHCN living in families in communities including: funding for waiver services to 196 children and adults to prevent placements into state institutions; funding for 120 children with developmental disabilities aging out of foster care; and support for the transition of children under age 22 residing in ICFs to move to families during the FY10-11 biennium. HHSC was directed to establish the Task Force for Children with Special Needs to identify barriers to community service delivery and find ways to improve service quality that will allow children to remain at home. The legislature also funded

additional 1915(c) Medicaid waiver slots to serve adults and children waiting for community services.

Title V staff continued to participate in community forums including Children's Policy Council, Consumer Directed Services Workgroup, MFP state and regional workgroups, Promoting Independence Advisory Council, Texas Integrated Funding Initiative, and Texas Council for Developmental Disabilities. CSHCN SP contractors and regional staff participated in community forums, committee meetings, and local Community Resources Coordination Groups.

In FY09, the number of children residing in nursing homes in Texas fell below 100. This is the first time the number has dropped below 100 since the enactment of SB 368 in FY01.

Performance Assessment: As of February 28, 2009, 1,613 children resided in institutions, 99.7% of the 2003 base year and represented a decrease of 0.7% from FY08. While the total number of children in institutions as defined by SB368 has remained fairly steady, residential settings continue a shift to smaller, less restrictive environments. Barriers identified for CYSHCN living successfully in the community with families include: inadequate specialized community supports, medical services, attendant care, behavioral intervention, and respite. CYSHCN SP is committed to permanency planning principles to support all CSHCN living with families in communities. The data analysis conducted by EveryChild, Inc. will help identify opportunities for systems change and improvement in service delivery. CYSHCN will benefit from interagency collaboration of high level decision makers in the Task Force for Children with Special Needs. Contractors and case management activities help provide and improve community and family supports services for children.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide, or support the provision of, permanency planning and case management services to families of CSHCN who are at risk of, or in an out-of-home placement.		X		
2. Fund respite and other family support services through contracts and CSHCN SP Healthcare Benefits.		X		
3. Collaborate with contractors, state agencies, and other entities to support permanency planning and family-based living options for CSHCN who reside in or are at risk of placement in congregate care settings.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: During the 1st half of FY10, CSHCN Services Program (SP) regional staff and contractors assisted 461 CYSHCN and their families with permanency planning.

Activity 2: During the 1st half of FY10, CSHCN SP provided family support services including both respite and van and home modifications for 37 health care benefits clients. CSHCN SP contractors provided workshops on important topics for CYSHCN and their families. Contractors provided funds for respite, equipment, supplies, counseling, and expenses not covered by other sources.

Activity 3: Through funding from CSHCN SP, EveryChild, Inc. prepared and released an extensive, 40 page literature review "Precarious Pathways: Use of Residential Congregate Care by Children with Developmental Disabilities," by Nancy Rosenau, Ph.D, Executive Director, and developed screening tools to assist in identifying reasons for initial and continued placement of children in institutions and resources and services needed to move children to family-based alternatives. The link to the literature review is : http://www.everychildtexas.org/PDFs/Literature%20Review%20CC%202010.pdf.

The Agency on Aging awarded the Department of Aging and Disability Services (DADS) $200,000 to create a Texas Respite Coordination Center to conduct statewide respite forums, compile an Inventory of Respite Services, and create best-practice toolkits for respite providers. As reported in NPM 4, the YES Medicaid waiver began its interest list.

An attachment is included in this section.

c. Plan for the Coming Year

Activity 1: Provide and assess the provision of permanency planning services to families of CYSHCN who reside in or are at risk of placement in congregate care settings.

Output Measure(s): Number of CYSHCN assisted with permanency planning by CSHCN SP regional and contractor case management staff; information from HHSC Permanency Planning and Family-Based Alternatives Report (Senate Bill 368) such as number of children living in congregate care settings, number of permanency plans completed by DADS and DFPS for children living in congregate care settings, number of children living in congregate care settings recommended for transition to the community number of children leaving institutions and placement in a family-based setting or placement in less restrictive environment other than a family-based setting, and trends in admission, discharge, placement; results of data analysis of permanency plans, as available.

Monitoring: Review quarterly regional activity reports, contractor quarterly reports, data from the HHSC Permanency Planning and Family-Based Alternatives Report (Senate Bill 368), and data analysis of permanency plans, as available.

Activity 2: Fund and promote respite and other family support services through contracts, CSHCN SP health care benefits, and collaboration with other entities.

Output Measure(s): Number of respite and other family support services programs funded and promoted through CSHCN SP contracts; number of CYSHCN provided respite and other family support services (FSS) through CSHCN SP contractors and health care benefits; number of total respite hours provided by CSHCN SP contractors and health care benefits.

Monitoring: Review quarterly reports from the CSHCN SP health care benefits database and contractor quarterly reports.

Activity 3: Collaborate with public and private entities to support permanency planning and family-based living options for CYSHCN who reside in or are at-risk of placement in congregate care settings.

Output Measure(s): Documentation of participation in related committee, agency, or organization meetings; documentation of recommendations or actions of related committee/agency meetings; reports of related contractor activities.

Monitoring: Review Stakeholder Meeting reports on relevant meetings attended by CSHCN SP staff, contractor quarterly reports, and reports of other activities.

State Performance Measure 2: *The percent of obesity among women ages 18 to 44*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		23	22.5	22	26.5
Annual Indicator	23.6	24.5	27.3	27.0	28.1
Numerator		1129922	1273668	1277796	1343704
Denominator		4613620	4666871	4732576	4781864
Data Source				Behavioral Risk Factor Surveillance System	Behavioral Risk Factor Surveillance System
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	26	26	25.5	25.5	

Notes - 2009
BRFSS is a sample survery, therefore, the numerator and denominator are not available. The annual indicator is the point estimate of the data collected after weighting. Denominator data provided by the Office of the State Demographer. Numerator data are calculated by muliplying the percent from BRFSS and the total number of women 18 to 44 years of age.

Notes - 2008
BRFSS is a sample survery, therefore, the numerator and denominator are not availale. The annual indicator is the point estimate of the data collected after weighting. Denominator data provided by the Office of the State Demographer. Numerator data are calculated by muliplying the percent from BRFSS and the total number of women 18 to 44 years of age.

Notes - 2007
BRFSS is a sample survery, therefore, the numerator and denominator are not availale. The annual indicator is the point estimate of the data collected after weighting. Denominator data provided by the Office of the State Demographer. Numerator data are calculated by muliplying the percent from BRFSS and the total number of women 18 to 44 years of age.

a. Last Year's Accomplishments
Activity 1: Contacts for FY09 included 38 trainings/workshops, 68 presentations, 10 referrals, and 227 technical assistance activities reaching organizations including schools and education-related organizations, public health organizations, advocacy groups, governmental organizations, health care organizations, community organizations, and business/industry. Topics included: improving nutrition through evidence-based worksite wellness activities; community collaboration related to nutrition and physical activity choices; weight maintenance/control; food additives/preservatives; diabetes and nutrition; child nutrition/obesity; physical activity; farm direct/farm to work program development; decreased consumption of sugar sweetened beverages and high energy dense foods; increased consumption of fruits and vegetables; increased breastfeeding; childhood obesity prevention through improved nutrition practices in the day care setting; decreased screen time; and nutrition environment assessment. The opening of a city skateboard park was a policy/environmental change that was implemented.

Activity 2: Thirteen new policy/environmental changes were completed, including: business

worksite wellness program/lactation support; extended lease of current farmers market; worksite physical activity prompts posted; worksite point-of-purchase prompts posted; one community breastfeeding support center opened; two Farmers Markets implemented; one community garden initiated, and Farm Direct program started at 14 new worksites. One environmental change was accomplished at a state agency worksite in Houston when two rooms were dedicated as space for employees to engage in physical activity/exercise as part of the overall organizations worksite wellness program.

Activity 3: 2006 birth certificate data indicate 25.1% of women ages 18 to 44 were overweight and 21.1% were obese pre-pregnancy. 2007 PRAMS data shows rates of 22.1% overweight and 23.1% obese pre-pregnancy. 2008 Texas Behavioral Risk Factor Surveillance System (BRFSS) data shows 27.4% of women ages 18 to 44 were obese.

Performance Assessment: The percentage of women 18-44 who are obese increased slightly between 2007 and 2009. Analysis of the impact of the October 2009 WIC Food Package changes will be conducted. A focus on breastfeeding as primary prevention for obesity as well as future efforts targeting obese children may contribute to improvement in this measure.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. DSHS Nutrition, Physical Activity and Obesity Prevention (NPAOP) staff will conduct trainings and provide technical assistance to support community-level policy and environmental changes that address CDC evidence-based obesity prevention strategies.			X	X
2. DSHS NPAOP staff will contribute to the implementation of policy and environmental changes that address the CDC evidence-based obesity prevention strategies related to nutrition in a minimum of 6 communities.			X	X
3. Monitor obesity rates among women ages 18 to 44 years through the analysis of previously collected surveillance data (WIC annual Infant Feeding Practices Survey, Pregnancy Risk Assessment Monitoring System [PRAMS], Texas BRFSS).				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Regional staff for Title V continued to provide information through health fairs and participation in community coalitions and workgroups related to diabetes, physical activity and exercise, including Walk Across Texas campaign planning, nutrition, children's health, and community gardening. Nearly 1,200 women and infants were served through selected regional activities.

Regional staff and community contractors supported by those staff and Central Office Nutrition, Physical Activity, and Obesity Prevention Program staff have conducted 62 presentations, 37 workshops/trainings, 129 technical assistance activities, and 11 referrals.

Activity 2: Two policy and environmental changes were accomplished in January 2010. One was

in HSR 8, Center Point (CP) Independent School District (CPISD), in Kerr County. They created an Employee & CP Community Adult Fitness Room to improve the access/availability to physical activity opportunities. The CPISD Superintendent converted the middle school teacher's lounge to a fitness room open to all ISD staff and CP community members. All services are free to residents.

CPISD established a salad bar. Based on survey results from CPISD students, the ISD's School Health Advisory Council worked with ISD administration to purchase and install equipment for salad bar to increase consumption of fruits and vegetables.

Activity 3: 2008 Texas BRFSS data indicate 28% of women ages 18 to 44 years were overweight and 27.4% were obese.
An attachment is included in this section.

c. Plan for the Coming Year
The current State Performance Measure will be discontinued in FY11.

New SPM02: Rate of excess feto-infant mortality in Texas.

Activity 1: Identify excess feto-infant mortality using the Perinatal Periods of Risk (PPOR) map.

Output Measure(s): PPOR map developed for Texas.

Monitoring: PPOR map.

Activity 2: Complete analyses to identify and prioritize factors with greatest contribution to feto-infant death disparities.

Output Measure(s): Number and type of analyses completed; method for prioritization identified; report of identified prioritized factors developed.

Monitoring: Document analyses and priorities.

Activity 3: Communicate findings of PPOR analyses to stakeholders.

Output Measure(s): Communications developed; communications disseminated; number and types of stakeholders; number and types of feedback received.

Monitoring: Document communication and feedback received.

Activity 4: Develop and disseminate materials and activities aimed at increasing awareness about infant health promotion and prevention of feto-infant mortality.

Output Measure(s): Public awareness, educational materials, and activities developed; dissemination methods identified; materials and information disseminated.

Monitoring: Document materials, activities, and dissemination methods; review quarterly Health Service Region reports.

State Performance Measure 3: *Percent of licensed child care centers in metropolitan counties that have no deficiencies in operational policies that address health and safety of children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		90	90	90.5	42
Annual Indicator	0.0		30.1	41.6	50.6
Numerator	0		2806	3772	4684
Denominator	55	7500	9319	9057	9254
Data Source				Department of Family and Protective Services	Department of Family and Protective Services
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	42.3	42.7	43	43.5	

Notes - 2009
Annual indicator is the percentage of licensed child care centers in metropolitan statistical area (MSA) counties with no deficiencies in the following areas and sub areas of the Minimum Standard Rules for Licensed Child-Care Centers, September 2006 (p20330-000) published by the Texas Department of Family and Protective Services (DFPS). Areas include Health Practices (environmental health, diaper changing, illness and injury), Safety Practices (safety precautions, medication, animals at the child-care center, first-aid kits, release of children), Swimming Pools and Wading/Splashing Pools, and Fire Safety and Emergency Practices (fire inspection, emergency evacuation, and relocation, fire extinguishing and smoke detection systems, gas in propane tanks, heating devices, carbon monoxide detection systems), minimum requirements for outdoor equipment safety, and basic requirements for snack and mealtimes specific to choking.

Notes - 2008
Annual indicator is the percentage of licensed child care centers in metropolitan statistical area (MSA) counties with no deficiencies in the following areas and sub areas of the Minimum Standard Rules for Licensed Child-Care Centers, September 2006 (p20330-000) published by the Texas Department of Family and Protective Services (DFPS). Areas include Health Practices (environmental health, diaper changing, illness and injury), Safety Practices (safety precautions, medication, animals at the child-care center, first-aid kits, release of children), Swimming Pools and Wading/Splashing Pools, and Fire Safety and Emergency Practices (fire inspection, emergency evacuation and relocation, fire extinguishing and smoke detection systems, gas an propane tanks, heating devices, carbon monoxide detection systems), minimum requirements for outdoor equipment safety, and (basic requirements for snack and mealtimes specific to choking).

Notes - 2007
This is an estimate based on data provided through the annual report prepared by Texas Department of Family and Protective Services.

Further analysis based on targeted metropolitan statistical areas is ongoing.

a. Last Year's Accomplishments
Activity 1: Title V MCH staff gathered information on the number of completed critical or serious injury intakes at hospitals due to injury at child care facilities. As expected, areas with high injury were situated in the major metropolitan areas (Dallas/Fort Worth, Houston, San Antonio and Austin). This information, combined with the Department of Family and Protective Services (DFPS) child care licensing data, guided the development a poster and brochure on injury prevention and nutrition and physical activity in child care settings (See Attachment IV. C. SPM03 - Accomplishments). Posters were translated into Spanish and printing was completed during

FY09. The distribution plan developed in FY09 that included distribution through the Healthy Child Care Texas (HCCT) program and DFPS licensing; the DSHS Maternal and Child Health website; a podcast release and GovDelivery notification sent to approximately 800 DSHS subscribers; email notification to regional DSHS community health staff; and distribution to approximately 100 Health and Human Service Commission staff and stakeholders will be implemented in early FY10.

Performance Assessment: There was a 22% increase in the percent of licensed child care centers in metropolitan counties that have no deficiencies in operational policies that address health and safety of children. Information and resources continue to be developed for distribution to child care centers in order to improve deficiency rates.
An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Explore opportunities with DFPS Child Care Licensing to identify child care facilities with greatest infractions and provide targeted health and safety information.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activity 1: Healthy Child Care Texas (HCCT) reported 29 encounters with child care and Head Start facilities (trainings and consultations) on health and safety topics including abuse and neglect, child development, using community resources, cultural sensitivity, environmental health, infectious disease, injury prevention, mental health, nutrition, oral health, physical activity, playground safety, caring for children who are temporarily ill, caring for children with special needs, health and safety of staff, toilet training, and disaster preparedness. Some of these are also classroom/program environmental assessments. In these encounters, 154 administrators and 300 staff were served, encompassing service to 4,640 children.

Activity 2: While no HCCT committee meetings were held in the first quarter, the HCCT Task Force will reconvene in March 2010. DSHS will maintain its place on this task force.

An attachment is included in this section.

c. Plan for the Coming Year
This State Performance Measure will be discontinued in FY11.

New SPM03: The extent to which programs enhance statewide capacity for public health approaches to mental and behavioral health for MCH populations.

Activity 1: Assess current level at which programs are working to enhance statewide capacity to address mental and behavioral health for MCH population.

Output Measure(s): Number of surveys distributed to MCH programs; number and type of MCH programs responding to survey; assess what has already been accomplished by the Mental Health Transformation work group efforts and other efforts around the agency.

Monitoring: Review of annual survey results.

Activity 2: Develop cross divisional opportunities for programs to increase capacity in addressing mental and behavioral health in MCH populations.

Output Measure(s): Number of cross divisional partnerships; number and type of activities implemented.

Monitoring: Summary of partnerships and activities.

Activity 3: Partner with internal and external partners to enhance and incorporate mental and behavioral health for MCH populations into their efforts.

Output Measure(s): Number of meetings and types of partners engaged; number and type of activities implemented.

Monitoring: Document meetings or plans developed with partners.

Activity 4: Increase opportunities to enhance and improve the quality of the data sources related to mental and behavioral health.

Output Measure(s): Number of data sources that collect information about mental and behavioral health.

Monitoring: Use of data in reports, grants, and other documents; review quarterly Health Service Region reports.

State Performance Measure 4: *The proportion of women between the ages of 18 and 44 who are current cigarette smokers.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		17.5	17	16.5	16
Annual Indicator	18	15.9	18.1	15.7	14.1
Numerator		733256	846808	743014	674243
Denominator		4613620	4666871	4732576	4781864
Data Source				Behavioral Risk Factor Survey	Behavioral Risk Factor Survey
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	15.5	15	14.5	14	

Notes - 2009
BRFSS is a sample survery, therefore, the numerator and deonminator are not available. The annual indicator is the point estimate of the data collected after weighting. Denominator data

provided by the Office of the State Demographer. Numerator data are calculated by muliplying the percent from BRFSS and the total number of women 18 to 44 years of age.

Notes - 2008
BRFSS is a sample survery, therefore, the numerator and deonminator are not availale. The annual indicator is the point estimate of the data collected after weighting. Denominator data provided by the Office of the State Demographer. Numerator data are calculated by muliplying the percent from BRFSS and the total number of women 18 to 44 years of age.

Notes - 2007
BRFSS is a sample survey, therefore, the numerator and denominator data are not available. The annual indicator is the point estimate of the data collected after weighting. Data are provisional because the weights were calculated by DSHS and the final weights have not been received from the CDC yet.

a. Last Year's Accomplishments
Activity 1: Yes You Can Clinical Toolkits (Toolkits) were produced, and 1,500 Toolkits were distributed to 6 statewide Tobacco Prevention and Control Coalitions (TPCCs) and 11 Prevention Resource Centers (PRCs) throughout the state. TPCCs and PRCs distributed Toolkits and CDs containing downloadable files of the Toolkit materials to health care providers and consulted with them concerning promotion of the Toolkit guidelines. TPCCs also received DVDs with public service announcements (PSAs) (Yes You Can Share Air/ Secondhand Smoke featuring the Quitline referral information) to distribute to clinics/hospitals/offices to display to patients on close circuit TVs.

Activity 2: Attendees at Minors and Tobacco sessions included 12,062 youth and 2,454 adults. Tobacco cessation information was distributed to 20,555 adults. The DSHS Tobacco Prevention and Control Program (TPCP) utilized Title V funding to conduct a media outreach campaign targeting women who smoke. The media flight began April 27, 2009 as part of a two-week run prior to Mother's Day on May 10. The advertisements ran in the six TPCCs' media markets (Austin, Fort Bend-Houston, Lubbock, Midland-Odessa, San Antonio, and Tyler-Longview).

The media outreach campaign proposed to impact the number of women who would be moved to call the American Cancer Society's telephone cessation Quitline as part of their first steps towards quitting the use of tobacco products.

During the two-week media flight, there were 202 callers to the Quitline from the 6 coalition media markets, which accounted for 56% of all calls during that time frame. During the months of April and May 2009, 544 of the 1,032 women who called the Quitline were from those 6 markets. Six of the women from the target areas were pregnant at the time they called. Also during those months, female callers outnumbered men 5:3 in both the targeted market areas as well as the entire state. Of those callers from the coalition areas, 874 received counseling and other services to help quit smoking.

A Texas study in 2006 for the Center for Health Research at Kaiser Permanente found that for every Texan who quits smoking, there is a five-year savings of $8,127 in medical costs and lost productivity. For this $250,000 investment in media promoting quitting in six Texas communities, there is a potential return of $1.9 million through reduced future medical costs and increased productivity.

Performance Assessment: The rate of tobacco use among women 18-44 years of age dramatically declined between 2007 and 2009. Tobacco prevention is integrated into a variety of public health efforts and this has contributed to the decline in this measure. Future work will focus on targeting pregnant women with tobacco cessation messages and interventions and continue with population based prevention efforts.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide smoking cessation training using the Yes You Can Clinical Toolkit to include staff from WIC, DSHS regions, prenatal contractors, Department of Family and Protective Services, and other key stakeholders.			X	
2. Distribute cessation and secondhand smoke educational materials (targeted to pregnant women) through Prevention Resource Centers.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: The Yes You Can Clinical Toolkits (Toolkits) were produced in the 1st quarter, with 1,500 Toolkits distributed to 6 statewide Tobacco Prevention and Control Coalitions (TPCCs) and 11 Prevention Resource Centers (PRCs) throughout the State. TPCCs and PRCs distributed these toolkits and CD's containing downloadable files of the Toolkit materials to physicians and health care professionals in their region in the first and second quarters. The Toolkit was made available to be downloaded from the Yes You Can website, www.yesquit.org, by the general public as well as health care providers in the second quarter. The Texas Tobacco Prevention and Control Program also began to distribute Yes You Can TV commercials as PSAs throughout the state's TV markets.

Activity 2: Attendees at Minors and Tobacco sessions included 10,212 youth and 4,943 adults in the first quarter and 12,033 youth and 2,826 adults in the second quarter. Tobacco cessation materials were distributed to 13,841 adults in first quarter and 12,222 in the second quarter.

Activity 3: According to 2007 PRAMS data, 8.3% of pregnant women smoked in their last 3 months of pregnancy. The incidence was highest in White women, at 14.8%, and lowest for Hispanic women at 3.3%. Also, women whose income was less than $15,000 per year were much more likely to smoke in the last 3 months of pregnancy (13.4%) versus women who made more than $50,000 per year (4.1%).

An attachment is included in this section.

c. Plan for the Coming Year

Activity 1: Provide smoking cessation training using the Yes You Can Clinical Toolkit to health care professionals using Texas Tobacco Prevention and Control Coalitions and regional Prevention Resource Center staff.

Output Measure(s): Number of trainings held; number of toolkits distributed; number of referrals to Quitline by health care professionals.

Monitoring: Quarterly total of training sessions held; materials distributed; and Quitline referrals made.

Activity 2: Distribute cessation and secondhand smoke educational materials through Texas

Tobacco Prevention and Control Coalitions and regional Prevention Resource Centers.

Output Measure(s): Number and type of materials distributed.

Monitoring: Number of materials distributed and the number of hits to yesquit.org website.

Activity 3: Monitor smoking rates among women aged 18-44 by race and ethnicity and by pregnancy status through the analysis of previously collected surveillance data.

Output Measure(s): Percent of women aged 18-44 who smoke by race and ethnicity, percent of women who smoked prior to pregnancy, percent of women who smoked during pregnancy, and percent of women who smoke in the postnatal period.

Monitoring: Review birth record, PRAMS, and Texas BRFSS data as available.

State Performance Measure 5: *The prevalence of at-risk for obesity and obesity among adolescents enrolled in high school*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		28	27	26	31
Annual Indicator	29	29.0	31.6	31.4	29.2
Numerator		363380	403049	406733	380582
Denominator		1253033	1275472	1297130	1303363
Data Source				Youth Risk Behavior Survey	Youth Risk Behavior Survey
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	31	30	30	29	

Notes - 2009
The Youth Risk Behavior Survey is conducted every other year in odd years. While point estimates are repeated in the even years, adjustments based on population change are reported. Denominator data are from Enrollment in Texas Public Schools report (Source: Texas Education Agency: http://ritter.tea.state.tx.us/research/pdfs/enrollment_2008-09.pdf). Numerator data are calculated by multiplying the point estimate from the Youth Risk Behavior Survey and the enrollment data in the denominator.

Notes - 2008
The Youth Risk Behavior Survey is conducted every other year in odd years. While point estimates are repeated in the even years, adjustments based on population change are reported. Denominator data are from Enrollment in Texas Public Schools report. Numerator data are calculated by multiplying the point estimate from the Youth Risk Behavior Survey and the enrollment data in the denominator.

Notes - 2007
Source: Texas, 2007 Youth Risk Behavior Survey (YRBS).

a. Last Year's Accomplishments

Activity 1: DSHS staff collaborated with external survey developers and stakeholders to select and develop questions for the upcoming School Physical Activity Nutrition (SPAN) survey. The 4th grade, 8th grade, 11th grade, and parent questionnaires were completed and translated into Spanish. A focus group with 8th graders was conducted for survey readability from which valuable feedback was received resulting in further revisions. School district survey information packets and research applications were created. Surveys will be completed in FY10.

Activity 2: 7 contractors provided services to 676 children ages 2-12 through the Comprehensive Childhood Obesity Services program. At mid-year, this number was 732. After revisions contractors made to monthly reports, the total number of children served decreased to 676. At mid-year, one contractor voluntarily withdrew from the program due to lack of ability to meet contract requirements. The contractors received 1,392 referrals to the program and conducted 314 outreach activities in FY09. Due to widespread implementation issues such as lack of parental participation and motivation, difficulty with the referral process, and information sharing issues, the program was discontinued at the end of FY09.

Activity 3: Since the beginning of FY09, 109 different articles have been posted in the Friday Beat that discuss nutrition, cardiovascular disease, diabetes, physical activities, and other issues related to child and adolescent obesity. The Friday Beat is a weekly electronic newsletter that reaches over 1,200 teachers, school administrators, school nurses, and other professionals who work with school health and students. The Friday Beat may be found at http://www.dshs.state.tx.us/schoolhealth/fridaybeat.shtm.

Activity 4: Title V MCH staff collaborated with DSHS School Health and Nutrition, Physical Activity, and Obesity programs to develop The Get Fit Kit. The Get Fit Kit is a toolkit designed for school nurses to use with adolescents who have been identified through FitnessGram (the state's physical fitness assessment) as being overweight or obese. The toolkit includes six lessons both in English and Spanish on MyPyramid, portion control, reading nutrition labels, fast food and snacking, body mass index, physical activity, and diabetes. The toolkit comes with a student guide and a nurses' lesson guide that provides step-by-step instruction for delivering the lessons. The Get Fit Kit is also accompanied by a website (www.getfitkit.org) that contains all of the toolkit materials, interactive games and quizzes for students, and additional resources related to obesity prevention relevant to adolescents. Distribution of the toolkits will begin in FY10. The Health Service Region (HSR) Title V staff identified child and adolescent obesity as a priority area and began planning population-based activities to address child/adolescent obesity. Examples include assisting with the distribution of the Get Fit Kit to those school districts who do not have a school nurse, working with local obesity prevention coalitions, and conducting parent education.

See Attachment IV. C. SPM05 - Accomplishments for information on population-based obesity prevention activities.

Performance Assessment: According to the state's physical fitness assessment, FITNESSGRAM, data from 2008-2009 show that 8.8% of female 12th graders and 9.25% of male 12th graders achieved the healthy fitness zone of all 6 tests. YRBS data indicate that much of the high rates of adolescent obesity may be a result of decreased physical activity and unhealthy diets. As the surveillance of childhood obesity and related behaviors among fourth, 8th and 11th grade students and parents of the 4th graders continues, more is learned about environmental influences on obesity-related behaviors and challenges with addressing those influences. To affect the rates of adolescent obesity, future activities must address environmental and other confounding factors of obesity-related behaviors prior to adolescence.
An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Collaborate with the School Physical Activity Nutrition (SPAN) group to continue collecting data on demographics, nutrition behaviors, attitude and knowledge, and physical activity behaviors among 4th, 8th and 11th grade children.				X
2. Implement a pediatric obesity program targeting children ages 2-12 years to decrease the prevalence of adolescent obesity in the state of Texas.			X	
3. Work with DSHS Division of School Health to disseminate information and resources about the prevalence and risk factors associated with adolescent obesity to school administrators, teachers, school nurses, parents and students.			X	
4. Coordinate healthy living activities (i.e. healthy eating, physical activities) targeted to at-risk adolescents with internal and external stakeholders.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: During FY10, University of Texas School of Public Health (UTSPH) and the Michael and Susan Dell Center for Advancement of Healthy Living continued to recruit school districts for participation in the SPAN Project. Data collection began in January. Survey administration partners include: Gulf Coast Area Health Education Center, HSR Nutritionists, Scott & White, UTSPH Regional Campuses.

Activity 2: In FY10, a joint request for proposals (RFP) was released from the Office of Title V & Family Health; Nutrition, Physical Activity and Obesity Prevention; and Office of Border Health. The funds will be used for local community infrastructure building for obesity prevention activities. Title V-funded projects focus on strategies for children and adolescents. Projects will begin in the 3rd quarter of FY10.

Activity 3: 74 resources on child obesity, physical activity, and nutrition were issued to school administrators, teachers, school nurses, parents, and students through the weekly Friday Beat electronic newsletter. HSR staff provided information to School Health Advisory Councils and identified schools without a school nurse to assist in distributing Get Fit Kits.

Activity 4: Get Fit Kits, a toolkit for school nurses to use with adolescents identified through Acanthosis Nigricans screening or FITNESSGRAM as overweight or obese, were completed and statewide distribution began. The Get Fit Kits were promoted at the Texas School Nurse Conference in Dallas.

An attachment is included in this section.

c. Plan for the Coming Year

This State Performance Measure will be discontinued in FY11.

New SPM05: The percent of obesity among school-aged children (grade 3-12).

Activity 1: Collaborate with the School Physical Activity Nutrition (SPAN) workgroup to examine demographics, nutrition behaviors, attitude and knowledge, and physical activity behaviors among 4th grade children and their parents, 8th graders and 11th graders.

Output Measure(s): Prevalence of overweight and obesity among Texas school children by grade, gender and race/ethnicity; analysis to identify sociodemographic, social, and mental health correlates of obesity.

Monitoring: Monthly meetings to review study progress and outline dissemination activities.

Activity 2: Partner with external and internal stakeholders to identify opportunities and innovative interventions to prevent school-aged childhood obesity.

Output Measure(s): Number and type of activities implemented.

Monitoring: Quarterly review of implemented activities and overall progress.

Activity 3: Disseminate information and resources about the prevalence and risk factors associated with school-aged childhood obesity.

Output Measure(s): Number, type, and format of materials provided.

Monitoring: Quarterly review of information and resources distributed.

Activity 4: Coordinate and implement regional and local childhood obesity prevention activities.

Output Measure(s): Number and type of activities coordinated by or implemented by Health Service Region Staff; number of childhood obesity prevention activities provided through the Education Service Centers.

Monitoring: Review quarterly Education Service Center progress reports; review quarterly Health Service Region reports.

State Performance Measure 6: *The percent of Texas Health Steps eligible children provided preventive dental services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		42	42.5	43	43.5
Annual Indicator	41.5	40.0	42.1	41.6	44.3
Numerator	1051633	1047804	1112410	1224309	1379211
Denominator	2532422	2620912	2642556	2943128	3111775
Data Source				Form CMS-416: Annual EPSDT Participation Report	Form CMS-416: Annual EPSDT Participation Report
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	44	44.5	45	45	

Notes - 2009
Texas CMS-416 FFY 2009

Notes - 2008
Texas CMS-416 FFY 2008

Notes - 2007
Source: TMHP, HISR303A, AHMST069, SFY 2007.

a. Last Year's Accomplishments
Activity 1: The DSHS Oral Health Program (OHP) provided preventive dental services to 10,748 children, including 3rd graders, during FY09.

Activity 2: OHP continues to work collaboratively with school-based and community-based groups to promote oral health activities including the provision of preventive dental services such as dental sealants. DSHS OHP regional dental teams have worked with the City of Houston Health Department, Bexar Metro Health Department in San Antonio, the Lamar College Dental Hygiene Program in Beaumont, the San Antonio Parks and Recreation Summer Program, Health and Human Service Commission (HHSC) Office of Border Health, the City of El Paso Health Department, Lubbock Parks and Recreation Summer Program, and Operation Lone Star to provide preventive dental services including dental sealants for low-income children.

Activity 3: 69 on-site inspections were performed by the DSHS Fluoridation Program in FY09. Six technical assistance requests were responded to; two of which were in coordination with an on-site inspection. The majority of visits occurring in the second half of the year were directly related to grant projects and the construction and installation of injection equipment. Each visit took no less than one week to complete. Data reported reflects the number of systems visited, not the number of visits to each system. Three training classes were conducted in FY09.

Activity 4: OHP continues to work with the Texas Dental Association, Texas Academy of Pediatric Dentistry, Texas Academy of General Dentistry (TAGD), Texas Dental Hygienist's Association, and the Texas Head Start Collaboration Office to promote the concept of dental home and early intervention. OHP worked with the TAGD to pilot the Head Start Dental Home Initiative in Texas. OHP has also worked with Title V contractors and Medicaid dental providers to implement the First Dental Home strategic initiative in Texas promoting the establishment of a dental home for children starting at 6 months of age. Training materials on the First Dental Home initiative were developed with the inclusion of a variety of stakeholders as well as the development of parent questionnaires, caries risk assessment tool, dental anticipatory guidance materials, a parent educational take home, and visit documentation form.

Performance Assessment: There was a slight increase (6.5%) in 2009 of the number of Texas Health Steps eligible children provided preventive dental services; this increase placed Texas above the annual performance objective for the first time since 2006. Continued expansion of first dental home and oral evaluation and fluoride varnish trainings may have contributed to the increase in services provided.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide dental services to third graders across the state enrolled in the free and reduced lunch program.	X			
2. Continue to support collaborations to promote oral health prevention through water fluoridation and dental sealants.				X
3. Continue providing training to local water system operators, on-site inspections of system/equipment needs, and technical			X	

assistance to communities in need of fluoridation systems or upgrades.				
4. Collaborate with multiple stakeholders to develop activities and materials to promote the dental home concept and early intervention to both providers and recipients of services.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activity 1: For the first half of FY10, OHP dental teams provided preventive dental services to 7,135 children across the state.

Activity 2: OHP collaborated with local health departments, dental hygiene programs, and professional dental organizations to promote water fluoridation, preventive dental services including dental sealants, and support the establishment of dental homes for Head Start children. OHP is working on a letter to Medicaid enrolled dentists to update them on the current Medicaid policies and literature references on the current American Dental Association Taskforce guidelines on dental sealants.

Activity 3: In the first quarter, 7 site inspections were conducted at 5 public water systems and technical assistance was provided to all. Systems were located in Eagle Lake, Wharton, Bay City, Silsbee, and Seguin. Equipment was purchased and installed at 2 of the systems. The Fluoridation pamphlet was updated and is ready for printing.

Activity 4: OHP continues to provide training to pediatric and general dentists who provide dental homes for very young children (6-35 mo.) of Medicaid and Title V eligible families. OHP has also worked with the Texas Dental Association's Council on Access to Dental Care in Medicaid and CHIP and TAGD to raise awareness about the dental home concept and the importance of early intervention to prevent and/or decrease the occurrence of dental decay.

An attachment is included in this section.

c. Plan for the Coming Year
This State Performance Measure will be discontinued in FY11.

New SPM06: Rate of preventable child deaths (0-17 year olds) in Texas.

Activity 1: Expand Child Fatality Review (CFR) to cover more children in Texas to increase the understanding of risk and protective factors.

Output Measure(s): Numbers of inquiries about new teams, CFR presentations conducted, and number of newly-formed teams that review fatalities.

Monitoring: Quarterly review of number of teams and percentage of children living in counties with CFR.

Activity 2: Develop and implement a plan to increase the number of preventable child deaths reviewed, to improve the quality of the CFR data collected and to analyze data for Annual Report for recommendations of prevention activity direction, and other methods of dissemination.

Output Measure(s): Form Data Quality Workgroup in State CFRT Committee; create Data Quality Plan; deliver trainings on data collection and quality; and use data in Annual Report, fact sheets, presentations, reports and displays.

Monitoring: Quarterly review of data submitted shared with Data Quality Workgroup and SCFRT; data collection and quality issues addressed with teams quarterly.

Activity 3: Organize and facilitate internal and external stakeholders to address prevention of child drowning deaths.

Output Measure(s): Form Statewide Drowning Prevention Task Force to develop state plan to reduce drowning deaths.

Monitoring: Quarterly report from Task Force on progress.

Activity 4: Organize and facilitate internal and external stakeholders to address standardization of infant death scene investigations.

Output Measure(s): Establishment of Texas Sudden Unexpected Infant Death Investigation (SUIDI) Workgroup.

Monitoring: Quarterly reporting from Texas SUIDI Workgroup on progress.

State Performance Measure 7: *Rate of family violence incidents involving females victims per 1,000 women in Texas*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		11.9	11.7	11.5	12
Annual Indicator	13.1	13.0	12.8	12.5	12.7
Numerator	149681	152549	151092	151344	156055
Denominator	11440521	11754567	11849105	12060453	12276293
Data Source				Texas Department of Public Safety Crime Report	Texas Department of Public Safety Crime Report
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	12	11.7	11.3	11	

Notes - 2009
The number of female victims of family violence are from the annual Texas Crime Report, Chapter 5 - Family Violence (http://www.txdps.state.tx.us/administration/crime_records/pages/crimestatistics.htm). The report presents the total number of incidents and the percent of which were among females. The denominator data are from the Office of the State Demographer.

Notes - 2008
The number of female victims of family violence are from the annual Texas Crime Report, Chapter 5 - Family Violence (http://www.txdps.state.tx.us/administration/crime_records/pages/crimestatistics.htm). The Report presents the total number of incidents and the percent of which were among females. The denominator data are from the Office of the State Demographer.

Notes - 2007
Numerator Source: http://www.txdps.state.tx.us/crimereports/06/citi04ch5pdf from the Texas Department of Public Safety.

Data presents a projected linear trend for 2007 based on data from 2005 and 2006.

Population data for Texas are provided by the Texas Department of State Health Services, Center for Health Statistics, (http://www.dshs.state.tx.us/chs/popdat/detailX.shtm).

a. Last Year's Accomplishments
Activity 1: School Health Specialists (SHS) in the Education Service Centers have facilitated 25 dating violence/family violence workshops to 892 professionals. In addition, SHS conducted several types of activities on the topic of teen dating violence: 2 awareness sessions to 35 professionals, the distribution of dating violence guides to school personnel, 2 videoconferences to 70 professionals, and 2 student presentations to 180 students. Title V MCH staff participated in the Foundations of Change: A Statewide Summit to Create Strategies for the Future hosted by the Texas Council on Family Violence.

Activity 2: DSHS staff participated in 5 Rape Prevention Education (RPE) steering committee meetings and 3 Primary Prevention Planning Committee (PPPC) meetings. RPE gathered data in the first half of FY09 on sexual violence in Texas to set goals and strategies to guide the creation of the State Plan for the Primary Prevention of Sexual Violence. The State Plan will be completed in the first quarter of FY10. PPPC received feedback from CDC about the plan and changes have been incorporated into the final document. The plan was released to RPE funded organizations in November 2009.

Activity 3: Proposed state legislation recommending the addition of a Family Violence Service Provider to the roster of the State Child Fatality Review Team (SCFRT) Committee was not approved during the legislative session. The SCFRT plans to pursue involvement of a Family Violence Service Provider on the Committee as an Ad Hoc member, and will continue to seek to formalize this through statute during the next legislative session in FY11.

Activity 4: Title V MCH staff met with the coordinator of the Interpersonal Violence Prevention Collaborative (IVPC) to discuss how to improve the impact of the IVPC. The IVPC will continue on as virtual group for the time being with continued meetings between staff and the IVPC Coordinator to discuss strategic planning for this group. Fact sheets were developed on interpersonal violence, and a recommendation was made that a specific sheet be made to address the relationship between interpersonal violence and health and the role a health care provider plays in engaging survivors of interpersonal violence. Drafts of the fact sheets were reviewed by staff. The IVPC Coordinator also participated on the PPPC for the RPE State Plan.

Performance Assessment: The rate of family violence incidents involving females slightly increased between 2007 and 2009. There are new efforts underway to increase health care response to domestic violence and to integrate domestic violence awareness and intervention into other public health efforts. In addition, partnership with the Texas Council on Family Violence and the Office of the Attorney General will continue to impact this measure in the future.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase opportunities for family violence prevention activities at the state and local level.			X	X
2. Collaborate with the Office of the Attorney General on activities in conjunction with the RPE grant from the Centers for Disease Control and Prevention (CDC).				X
3. Integrate family violence prevention professionals into State Child Fatality Review Team (SCFRT) and local Child Fatality Review Teams.				X
4. Participate on the Interpersonal Violence Prevention Collaborative steering committee.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: In the first two quarters, the Texas School Health Network conducted 57 awareness raising workshops serving 2,557 people. Topics included bullying prevention, internet safety and cyber-bullying, dating violence prevention, gangs and gang violence, best practices used to make schools safer, child abuse, and teens who self injure. They also reached out to very large groups through their email distribution list and Friday Beat newsletter.

Activity 2: Title V MCH staff attended the October Primary Prevention and Planning Committee (PPPC) meeting. At this meeting, feedback from CDC on the Texas State Plan for the Prevention of Sexual Assault was discussed, as well as next steps and plans for release and implementation. In November, staff presented the State Plan with a panel of the PPPC at the Office of the Attorney General's 2009 Crime Victim Services Conference. In January, the Final State Plan was submitted to CDC and distribution and planning for implementation began in February.

Activity 3: In February 2010, the SCFRT prepared their recommendation for the legislature to include a family violence professional into the SCFRT. It will be considered in the 82nd Texas Legislative Session (2011).

An attachment is included in this section.

c. Plan for the Coming Year

This State Performance Measure will be discontinued in FY11.

New SPM07: The extent to which research findings and/or evidence-based practices are used to develop and improve DSHS programs serving MCH populations.

Activity 1: Assess current level at which programs are working to identify research findings and/or evidence-based practices for improving DSHS programs serving MCH populations.

Output Measure(s): Number of surveys distributed to DSHS programs; number and type of DSHS programs responding to survey; survey results indicating identification of research findings/evidence-based programs.

Monitoring: Review of annual survey results.

Activity 2: Increase cross-divisional opportunities to promote research findings and/or evidence-based practices in DSHS programs serving MCH populations.

Output Measure(s): Number, type, and format of activities implemented.

Monitoring: Documentation of materials/products distributed and activities completed.

Activity 3: Partner with external and internal stakeholders to identify opportunities to incorporate research findings/evidence-based practices.

Output Measure(s): Number of meetings and types of partners engaged; number and type of proposals developed for implementation; number and type of activities implemented.

Monitoring: Review meeting notes; copy of materials/plan developed.

E. Health Status Indicators

Introduction

The HSIs identify areas of success and concern. The percent of low birth weight (LBW) births have increased which may be explained by increases in multiple births because the percentage of LBW singleton births was the same in 2008 and 2009. Fatalities from unintentional injuries and motor vehicle crashes (MVC) decreased, as did the rate of nonfatal unintentional injuries among children 14 and younger and nonfatal MVC among 15 to 24 year olds. However, the nonfatal MVC among children 14 and younger increased. This indicator will be vital to understand the impact of future injury prevention, especially regarding motor vehicle safety for young children. Chlamydia rates continue to rise in Texas and the nation, indicating a continued need for increased attention to prevention activities focusing on women 15 to 44.

Texas is one of the only states to have population in urban, rural, and border areas. The majority of Texans reside in urban areas; however a sizable rural population still requires accessible services. Texas is also experiencing a demographic shift, being one of the states with the youngest overall population with a growing Hispanic segment that will become the largest population group among children by 2015. It will be increasingly important to consider the role of acculturation in health promotion and disease prevention and to ensure that interventions are appropriately tailored to Texas' unique needs.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	8.3	8.3	8.5	8.6	8.7
Numerator	32082	32453	33834	34803	35772
Denominator	385580	390702	398319	403974	409630
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and					

therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
All natality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1991 through 2006.

Notes - 2008
All natality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1991 through 2006.

Notes - 2007
All natality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1991 through 2006.

Narrative:
Low birth weight has steadily increased since 2000 moving further away from the Healthy People 2010 Objective of 5.0%. Between 2005 and 2009 (projected), there has been a 4.8% increase in this measure. In 2009 (projected), singletons accounted for 77.0% of all low birth weight, essentially unchanged from 77.3% in 2005. Given the relative consistency in the percent of very low birth weight deliveries among singleton births, the increase in very low birth weight deliveries among multiple births may contribute to the increase in this measure. Women receiving WIC and/or family planning services receive positive preconception health messages. The Texas Birth Defects Program works to ensure that women are aware of the need for folic acid supplementation prior to conception and in early pregnancy. Other programs throughout DSHS including the Tobacco Prevention and Control Program; Diabetes Program; and the Nutrition, Physical Activity, and Obesity Prevention Program also contribute to this measure by encouraging women to adopt the most beneficial health behaviors which support healthy fetal development.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.6	6.5	6.7	6.8	6.8
Numerator	24813	25021	26146	26845	27544
Denominator	374050	383887	391349	397657	403964
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
All natality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1991 through 2006.

Notes - 2008

All natality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1991 through 2006.

Notes - 2007
All natality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1991 through 2006.

Narrative:
Low birth weight among singletons has increased nearly every year since 2005. Between 2005 and 2009 (projected), there has been a 3.0% increase in this measure. The percent of singleton infants born low birth weight remained the same for 2008 and 2009, indicating that the increase in this indicator may be beginning to level off. Women receiving WIC and/or family planning services receive positive preconception health messages. The Texas Birth Defects Program works to ensure that women are aware of the need for folic acid supplementation prior to conception and in e arly pregnancy. Other programs throughout DSHS including the Tobacco Prevention and Control Program; Diabetes Program; and the Nutrition, Physical Activity, and Obesity Prevention Program also contribute to this measure by encouraging women to adopt the most beneficial health behaviors which support healthy fetal development.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.5	1.5	1.5	1.6	1.6
Numerator	5651	5788	6097	6317	6538
Denominator	385580	390702	398319	403974	409630
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
All natality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1991 through 2006.

Notes - 2008
All natality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1991 through 2006.

Notes - 2007
All natality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1991 through 2006.

Narrative:
Very low birth weight has seen minimal increases since 2005, indicating that the percent of infants born very low birth weight is starting to level off in Texas. Between 2005 and 2009 (projected), there was a 6.7% increase in very low birth weight deliveries, which equates to a 0.1

percentage point increase. The percent of very low birth weight deliveries in 2009 (projected) was 77.7% higher than the Healthy People 2010 Objective (0.9%). Given the relative consistency in the percent of very low birth weight deliveries among singleton births, the increase in very low birth weight deliveries among multiple births may contribute to the increase in this measure. Women receiving WIC and/or family planning services receive positive preconception health messages. The Texas Birth Defects Program works to ensure that women are aware of the need for folic acid supplementation prior to conception and in early pregnancy. Other programs throughout DSHS including the Tobacco Prevention and Control Program; Diabetes Program; and the Nutrition, Physical Activity, and Obesity Prevention Program also contribute to this measure by encouraging women to adopt the most beneficial health behaviors which support healthy fetal development.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.1	1.1	1.1	1.1	1.2
Numerator	4201	4207	4437	4554	4672
Denominator	374050	383887	391349	397657	403964
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
All natality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1991 through 2006.

Notes - 2008
All natality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1991 through 2006.

Notes - 2007
All natality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1991 through 2006.

Narrative:
Among singleton births, there has been minimal change in the percent of very low birth weight deliveries. There has been a slight 0.1 percent point increase in 2009 (projected), but no change from 2005 to 2008. This rate is higher than the Healthy People 2010 Objective of 0.9%. Women receiving WIC and/or family planning services receive positive preconception health messages. The Texas Birth Defects Program works to ensure that women are aware of the need for folic acid supplementation prior to conception and in early pregnancy. Other programs throughout DSHS including the Tobacco Prevention and Control Program; Diabetes Program; and the Nutrition, Physical Activity, and Obesity Prevention Program also contribute to this measure by encouraging women to adopt the most beneficial health behaviors which support healthy fetal development.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	10.0	9.3	9.3	9.1	8.9
Numerator	516	491	496	489	482
Denominator	5185439	5287340	5332129	5384151	5427678
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
All mortality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1999 through 2006.
Denominator data provided by the Office of the State Demographer.

Notes - 2008
All mortality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1999 through 2006.
Denominator data provided by the Office of the State Demographer.

Notes - 2007
All mortality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1999 through 2006.
Denominator data provided by the Office of the State Demographer.

Narrative:
The death rate for unintentional injuries for children aged 14 years and younger declined each year between 1999 and 2009 (projected). The number of unintentional injury fatalities declined to under 500 for the first time in 2005. Due to limitations in the TVIS system, the number of deaths reported for 2005 was based on an estimate and was entered into the system several years ago. TVIS does not allow data entry for years prior to 2007. The final number of deaths to children 14 years old and younger was 490 in 2005. Projections suggest that in 2009 the rate of unintentional injury fatalities declined to 8.9 per 100,000 children aged 14 years and younger. The network of local child fatality review teams throughout Texas and DSHS programs focusing on injury prevention have contributed to the decline in this measure.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	4.5	4.9	4.7	4.5	4.4

Numerator	234	259	248	244	239
Denominator	5185439	5287340	5332129	5384151	5427678
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
All mortality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1999 through 2006.
Denominator data provided by the Office of the State Demographer.

Notes - 2008
All mortality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1999 through 2006.
Denominator data provided by the Office of the State Demographer.

Notes - 2007
All mortality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1999 through 2006.
Denominator data provided by the Office of the State Demographer.

Narrative:
The mortality rate of unintentional injuries among children aged 14 years and younger as a result of motor vehicle crashes declined to 4.4 deaths per 100,000 children aged 14 years and younger in 2009. The unintentional injury mortality rate for children 14 years and younger has showed a steady decline since 2006. In 2005, fatalities due to motor vehicle crashes accounted for nearly half (45.3%) of all unintentional deaths in Texas. Projections for 2009 indicate that motor vehicle crashes accounted for 49.6% of all unintentional deaths.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	26.9	27.7	26.0	25.5	25.5
Numerator	945	1000	953	945	937
Denominator	3517845	3610691	3658558	3703880	3680312
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

All mortality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1999 through 2006.
Denominator data provided by the Office of the State Demographer.

Notes - 2008
All mortality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1999 through 2006.
Denominator data provided by the Office of the State Demographer.

Notes - 2007
All mortality data reported for 2007, 2008, and 2009 are estimates. Estimates are linear projections based on data from 1999 through 2006.
Denominator data provided by the Office of the State Demographer.

Narrative:
The fatality rate from unintentional injuries due to motor vehicle crashes per 100,000 youth aged 15 to 24 years has ranged from a high of 27.7 fatalities per 100,000 youth aged 15 to 24 years in 2006 to a low of 25.5 fatalities per 100,000 youth aged 15 to 24 years in 2008 and 2009 (projected).

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	256.6	253.1	260.3	279.8	287.2
Numerator	13305	13383	13880	15067	15590
Denominator	5185439	5287340	5332129	5384151	5427678
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Numerator data are from the Texas EMS Trauma Registry. Denominator data are from the Office of the State Demographer.

Notes - 2008
Numerator data are from the Texas EMS Trauma Registry. Denominator data are from the Office of the State Demographer.

Notes - 2007
Data presents a projected linear trend for 2005 through 2007 based on data from 2002 through 2004. Numerator provided by the Texas EMS Trauma Registry.

Population data for Texas are provided by the Texas Department of State Health Services, Center for Health Statistics, (http://www.dshs.state.tx.us/chs/popdat/detailX.shtm).

Narrative:
From 2005 through 2007, there were approximately 13,000 nonfatal injuries among children aged 14 years and younger. This number increased to approximately 15,000 in 2008 and 2009. For 2009, the ratio of nonfatal to fatal unintentional injuries was 32.3:1. The ratio for 2008 was 30.4:1 indicating that there has been a decrease in the number of fatal injuries compared to the number of nonfatal injuries. Information gathered from local child fatality review teams may be used to develop interventions to reduce the number of injuries among children aged 14 years and younger.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	53.5	43.8	43.1	42.5	38.9
Numerator	2772	2318	2296	2286	2109
Denominator	5185439	5287340	5332129	5384151	5427678
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Numerator data are from the Texas EMS Trauma Registry. Denominator data are from the Office of the State Demographer.

Notes - 2008
Numerator data are from the Texas EMS Trauma Registry. Denominator data are from the Office of the State Demographer.

Notes - 2007
Data presents a projected linear trend for 2005 through 2007 based on data from 2002 through 2004. Numerator provided by the Texas EMS Trauma Registry.

Population data for Texas are provided by the Texas Department of State Health Services, Center for Health Statistics, (http://www.dshs.state.tx.us/chs/popdat/detailX.shtm).

Narrative:
Since 2005, there have been more than 2,000 nonfatal injuries annually among children aged 14 years and younger. The number of nonfatal injuries decreased steadily between 2005 and 2009, with a high of 2,772 in 2005 to a low of 2,109 in 2009. While motor vehicle crashes accounted for approximately half of all unintentional injury fatalities, in 2009, motor vehicle crashes accounted for 13.5% of all nonfatal injuries.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	181.0	177.5	173.7	167.8	158.8
Numerator	6369	6408	6356	6216	5846
Denominator	3517845	3610691	3658558	3703880	3680312
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Numerator data are from the Texas EMS Trauma Registry. Denominator data are from the Office of the State Demographer.

Notes - 2008
Numerator data are from the Texas EMS Trauma Registry. Denominator data are from the Office of the State Demographer.

Notes - 2007
Data presents a projected linear trend for 2005 through 2007 based on data from 2002 through 2004. Numerator provided by the Texas EMS Trauma Registry.

Population data for Texas are provided by the Texas Department of State Health Services, Center for Health Statistics, (http://www.dshs.state.tx.us/chs/popdat/detailX.shtm).

Narrative:
Since 2005, there have been approximately 6,000 nonfatal injuries annually among children aged 15 through 24 years. The number of nonfatal injuries decreased between 2005 and 2009, with a high of 6,408 in 2006 to a low of 5,846 in 2009. In 2009, the ratio of nonfatal unintentional injuries due to motor vehicle crashes among youth 15 to 24 years of age and 14 years of age or under is 6.2:1. The 2008 national rate (latest year available on CDC WISQARS) of nonfatal unintentional injuries due to motor crashes among youth 15 to 24 years of age (174.7 nonfatal injuries per 10,000 population) was 4.1 percent higher than the Texas rate in 2008 (167.8 nonfatal injuries per 10,000 population).

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	25.8	25.6	27.8	31.8	34.0
Numerator	22025	22583	24946	28928	30350
Denominator	854287	880975	895967	908436	892954
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Numerator data are from the Texas Department of State Health Services HIV/STD Program. Denominator data are from the Office of the State Demographer.

Notes - 2008
Numerator data are from the Texas Department of State Health Services HIV/STD Program. Denominator data are from the Office of the State Demographer.

Notes - 2007
Numerator provided by HIV/STD Epidemiology and Surveillance. Data presents a projected linear trend 2007 based on data from 2000 to 2006.

Population data for Texas are provided by the Texas Department of State Health Services, Center for Health Statistics, (http://www.dshs.state.tx.us/chs/popdat/detailX.shtm).

Narrative:
The rate of Chlamydia among women 15 to 19 years of age in Texas increased in 2007, 2008, and 2009. The rate of 34.0 cases per 1,000 women 15 to 19 years is a 31.8% increase over the rate in 2005. The Chlamydia rate has been over 30 for the past two years. The Chlamydia rates for Texas women 15 to 19 years of age were similar to the US rates. The Texas rate was lower than the US rate in 2005, 2006, and 2007. The Texas rate (32.7 cases per 1,000 women) was higher than the US rate (32.6 cases per 1,000 women) in 2008 (latest year available for the US). Increased collaboration between the Texas TB/HIV/STD Unit and the Texas Family Planning Program may help to turn the direction of this trend. A program to increase Chlamydia testing and diagnosis in family planning clinics has demonstrated early success.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	8.4	8.5	9.4	10.7	11.0
Numerator	35012	36124	40635	46526	48639
Denominator	4170872	4263884	4310753	4366483	4418294
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Numerator data are from the Texas Department of State Health Services HIV/STD Program. Denominator data are from the Office of the State Demographer.

Notes - 2008

Numerator data are from the Texas Department of State Health Services HIV/STD Program. Denominator data are from the Office of the State Demographer.

Notes - 2007
Numerator provided by HIV/STD Epidemiology and Surveillance. Data presents a projected linear trend 2007 based on data from 2000 to 2006.

Population data for Texas are provided by the Texas Department of State Health Services, Center for Health Statistics, (http://www.dshs.state.tx.us/chs/popdat/detailX.shtm).

Narrative:
The rate of Chlamydia among women 20 to 44 years of age increased each year from 2005 through 2009. The rate of 11.0 cases per 1,000 women 20 to 44 years is more than double the rate in 1996. The Chlamydia rate has been over 10.0 for the past two years. The Chlamydia rates for Texas women 20 to 39 years of age were similar to the US rates. The CDC interactive STD data website (http://wonder.cdc.gov/std-std-v2008-race-age.html) does not allow the user to break out the 20 to 44 year old age category. The Texas rate was lower than the US rate in 2005 and 2006. The rates were the same for 2007. The Texas rate (12.8 cases per 1,000 women) was lower than the US rate (13.8 cases per 1,000 women) in 2008 (latest year available for the US). Increased collaboration between the Texas TB/HIV/STD Unit and the Texas Family Planning Program may help to turn the direction of this trend. A program to increase Chlamydia testing and diagnosis in family planning clinics has demonstrated early success.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	398462	341055	42136	0	0	0	0	15271
Children 1 through 4	1552708	1326886	166836	0	0	0	0	58986
Children 5 through 9	1799907	1531300	203609	0	0	0	0	64998
Children 10 through 14	1676601	1401876	213298	0	0	0	0	61427
Children 15 through 19	1829806	1517115	242718	0	0	0	0	69973
Children 20 through 24	1850506	1544617	233181	0	0	0	0	72708
Children 0 through 24	9107990	7662849	1101778	0	0	0	0	343363

Notes - 2011

Narrative:
Approximately 96% of all children in Texas are either White or African American. The number of White children may be over-reported due to how race/ethnic data are collected in Texas. In Texas, race and ethnicity are often not asked separately. When collecting data, a common standard is to propose four racial/ethnic categories (White, African American, Hispanic, and

Other). This differs from the methodology implemented by the US Census. This presents a challenge when completing federal reporting requirements that solicit information separately for race and ethnicity. To address this barrier, children who have indicated that they are Hispanic using the four race/ethnic categorizations are included with the children that selected White. This is the only available solution that still allows the total of all children by race to equal the total number of all children by ethnicity.

Texas has one of the youngest populations in the United States. Over a third (37.0%) of the Texas population is under the age of 25 years old.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	188827	209635	0
Children 1 through 4	763140	789568	0
Children 5 through 9	951497	848410	0
Children 10 through 14	934070	742531	0
Children 15 through 19	1031212	798594	0
Children 20 through 24	1050088	800418	0
Children 0 through 24	4918834	4189156	0

Notes - 2011

Narrative:
A greater proportion of children of Hispanic origin are younger than children of non-Hispanic origin. When comparing children of Hispanic origin to children of non-Hispanic origins by age, the number of children of Hispanic origin in the 0 to 1 year of age group is 30.4% higher than the number of children of non-Hispanic origin. Children of non-Hispanic origin outnumber children of Hispanic origin in all other age groups except infants 0 to 1 and 1 to 4 years of age where the groups are relatively similar. The difference in the 0 to 1 year of age group signals the changing population dynamic that Texas will experience over the next decade.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	914	727	177	0	0	0	0	10
Women 15 through 17	18539	15680	2670	0	0	0	0	189
Women 18 through 19	34523	28991	5098	0	0	0	0	434
Women 20 through 34	299894	253063	33962	0	0	0	0	12869

Women 35 or older	45429	38137	3970	0	0	0	0	3322
Women of all ages	399299	336598	45877	0	0	0	0	16824

Notes - 2011
Source: Final Natality File, 2006. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.

Source: Final Natality File, 2006. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.

Source: Final Natality File, 2006. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.

Source: Final Natality File, 2006. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.

Source: Final Natality File, 2006. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.

Narrative:
Maternal age was younger among African American women than White women. Approximately 17% of births among African American women were to women under the age of 20 years compared to 13.5% among White women. Births among White women may be over-reported due to how race/ethnic data are collected in Texas. In Texas, race and ethnicity are often not asked separately. When collecting data, often four racial/ethnic categories (White, African American, Hispanic, and Other) are presented. This differs from the methodology implemented by the US Census. This presents a challenge when completing federal reporting requirements that solicit information separately for race and ethnicity. To address this barrier, children who have indicated that they are Hispanic using the four race/ethnic categorizations are included with the children that selected White. This is the only available solution that still allows the total of all births by race to equal the total number of all births by ethnicity.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	278	636	0
Women 15 through 17	6170	12369	0
Women 18 through 19	14156	20367	0
Women 20 through 34	153705	146189	0
Women 35 or older	26829	18600	0
Women of all ages	201138	198161	0

Notes - 2011
Source: Final Natality File, 2006. Texas Department of State Health Services, Center for Health Statistics.

Source: Final Natality File, 2006. Texas Department of State Health Services, Center for Health Statistics.

Source: Final Natality File, 2006. Texas Department of State Health Services, Center for Health Statistics.

Source: Final Natality File, 2006. Texas Department of State Health Services, Center for Health Statistics.

Source: Final Natality File, 2006. Texas Department of State Health Services, Center for Health Statistics.

Narrative:
Maternal age was younger among Hispanic women than non-Hispanic women. Approximately 17% of births among Hispanic women were to women under the age of 20 years compared to 10.2% among non-Hispanic women. Approximately three-quarters of all births occur to women ages 20 to 34 years (75.1%). One significant difference is in births to women 15 to 17 years of age. For Hispanic women, 6.2% of all births are accounted for by this age group compared to 3.1% among non-Hispanic women. A similar pattern is found among women 18 to 19 years of age. For Hispanic women, 10.3% of all births are accounted for by women 18 to 19 years of age compared to 7.0% among Hispanic women. This translates into birth rates among Hispanic women 15 to 19 years of age that are more than double those of non-Hispanic women. These numbers underscore the need for targeted adolescent pregnancy prevention efforts toward Hispanic adolescents. Texas has hosted a Hispanic Teen Pregnancy Prevention Summit that provided insight into the development of initiatives that could address this disparity in adolescent births.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	2476	1819	564	0	0	0	0	93

Children 1 through 4	448	344	88	0	0	0	0	16
Children 5 through 9	242	187	45	0	0	0	0	10
Children 10 through 14	345	275	60	0	0	0	0	10
Children 15 through 19	1092	917	154	0	0	0	0	21
Children 20 through 24	1721	1383	288	0	0	0	0	50
Children 0 through 24	6324	4925	1199	0	0	0	0	200

Notes - 2011
Source: Final Mortality File, 2006. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.

Source: Final Mortality File, 2006. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.

Source: Final Mortality File, 2006. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.

Source: Final Mortality File, 2006. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.

Source: Final Mortality File, 2006. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.

Source: Final Mortality File, 2006. Texas Department of State Health Services, Center for Health Statistics. Due to limitations in the reporting of the data, the total White population includes all Hispanic people regardless of race. Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.

Narrative:
Examining just the number of deaths reveals that there are more deaths among White children at all age groups. However, a study of the rates of death provides different information. The gap in child death rates between African American and White children ranges from 151.0% higher in the

0 to 1 year old age group to 5.0% higher in the 15 to 19 year old age group. On average, rates among African American children are 69.3% higher than rates among White children. Increased efforts to address child safety and injury prevention are needed. In the age group with the largest disparity, 0 to 1 year of age, efforts to promote safe infant sleep, especially among the family involved with child protective services may address this gap. The work of local child fatality review teams should also help to reduce these disparities.

Deaths among White children may be over-reported due to how race/ethnic data are collected in Texas. In Texas, race and ethnicity are often not asked separately. When collecting data, often four racial/ethnic categories (White, African American, Hispanic, and Other) are presented. This differs from the methodology implemented by the US Census. This presents a challenge when completing federal reporting requirements that solicit information separately for race and ethnicity. To address this barrier, children who have indicated that they are Hispanic using the four race/ethnic categorizations are included with the children that selected White. This is the only available solution that still allows the total of all children by race to equal the total number of all children by ethnicity.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	1404	1072	0
Children 1 through 4	245	203	0
Children 5 through 9	146	96	0
Children 10 through 14	201	144	0
Children 15 through 19	668	424	0
Children 20 through 24	1107	614	0
Children 0 through 24	3771	2553	0

Notes - 2011

Source: Final Mortality File, 2006. Texas Department of State Health Services, Center for Health Statistics.

Source: Final Mortality File, 2006. Texas Department of State Health Services, Center for Health Statistics.

Source: Final Mortality File, 2006. Texas Department of State Health Services, Center for Health Statistics.

Source: Final Mortality File, 2006. Texas Department of State Health Services, Center for Health Statistics.

Source: Final Mortality File, 2006. Texas Department of State Health Services, Center for Health Statistics.

Source: Final Mortality File, 2006. Texas Department of State Health Services, Center for Health Statistics.

Narrative:
The gap in child death rates between Hispanic and non-Hispanic children ranges from 136.5% higher in the 20 to 24 year old age group to 16.7% higher in the 1 to 4 year old age group. On average, rates among Hispanic children are 7.34% higher than rates among non-Hispanic children.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	7255037	6080655	906866	0	0	0	0	267516	2009
Percent in household headed by single parent	33.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2008
Percent in TANF (Grant) families	1.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2008
Number enrolled in Medicaid	3164233	2441717	557640	10538	53623	0	0	100715	2009
Number enrolled in SCHIP	490603	181300	22951	740	8666	0	0	276946	2009
Number living in foster home care	15932	10691	4903	49	52	0	0	237	2009
Number enrolled in food stamp program	3192055	2445114	673524	9576	35113	0	0	28728	2009
Number enrolled in WIC	1272325	1096999	142377	728	12518	1019	18684	0	2009
Rate (per 100,000) of juvenile crime arrests	2680.1	5319.5	5689.5	0.0	0.0	0.0	0.0	551.4	2009
Percentage of high school drop-outs (grade 9 through 12)	3.2	1.5	5.0	2.6	1.1	0.0	0.0	0.0	2008

Notes - 2011
Source: 2009 Population Projections provided by the Office of the State Demographer.
Information is not available by American Indian or Native Alaskan, Asian, Native Hawaiian or

Other Pacific Islander, or more than one race groups. Population in these groups are included in Other and Unknown.

Source: Annie E. Casey Foundation's KIDS COUNT 2009 Data Book Online (http://datacenter.kidscount.org/databook/2009/Default.aspx). Data are from 2008. Data are not available by race/ethnicity.

Source: Annie E. Casey Foundation's Texas Kids Count. Data are for 2008 and are based on children 0-17 years of age. Data are not available by race/ethnicity.

Source: ACS-Monthly Medicaid enrollment files. Demographic Analysis Unit, Strategic Decision Support, Health and Human Services Commission, Texas, 2009.

Source: ACS-Monthly Medicaid enrollment files. Demographic Analysis Unit, Strategic Decision Support, Health and Human Services Commission, Texas, 2009.

Source: Texas Food Stamp Client Profile, Strategic Decision Support, Health and Human Services Commission, Texas, 2008.

These data are reported through certification data provdied by the WIC program.

Source: Juvenille Crime Data report provided by the Texas Department of Public Safety. Maggie Walker, Statistician, Uniform Crime Reporting, maggie.walker@txdps.state.tx.us
Data are for 2009.

Rates for this measure were calculated incorrectly for prior years. Data for 2009 are not comparable to previous years.

Source: Texas Education Agency (http://ritter.tea.state.tx.us/research/pdfs/2009_comp_annual.pdf). Data are from the 2007/2008 academic year.

Source: Texas Department of Family and Protective Services (http://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2009/2009databook.pdf). Data from 2009.

Narrative:
White children accounted for 83.8% of the total child population in Texas. This figure may be over-reported due to how race/ethnic data are collected in Texas. In Texas, race and ethnicity are often not asked separately. When collecting data, often four racial/ethnic categories (White, African American, Hispanic, and Other) are presented. This differs from the methodology implemented by the US Census. This presents a challenge when completing federal reporting requirements that solicit information separately for race and ethnicity. To address this barrier, children who have indicated that they are Hispanic using the four race/ethnic categorizations are included with the children that selected White. This is the only available solution that still allows the total of all children by race to equal the total number of all children by ethnicity.

African American children account for 12.5% of the Texas population, but this figure may be under-represented as children who are African American and Hispanic are misclassified with the White group. While 12.5% of the entire population, African American children were overrepresented in several public aid programs. Sixy-one percent of African American children were enrolled in Medicaid compared to 40% of White children. The proportion of African American children enrolled in the food stamp program (74.3%) was nearly double that of White children (40.2%). Enrollment in WIC was similar between these groups. These data indicate a

need for increased targeting and cultural tailoring for interventions for African American children.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	3913286	3341751	0	2009
Percent in household headed by single parent	0.0	0.0	33.0	2008
Percent in TANF (Grant) families	0.0	0.0	1.4	2008
Number enrolled in Medicaid	1415912	1748321	0	2009
Number enrolled in SCHIP	351752	138851	0	2009
Number living in foster home care	9763	6169	0	2009
Number enrolled in food stamp program	1436425	1755630	0	2009
Number enrolled in WIC	342224	930101	0	2009
Rate (per 100,000) of juvenile crime arrests	2746.8	2605.1	0.0	2009
Percentage of high school drop-outs (grade 9 through 12)	0.0	4.4	0.0	2008

Notes - 2011
Source: 2009 Population Projections provided by the Office of the State Demographer.

Source: Annie E. Casey Foundation's KIDS COUNT 2009 Data Book Online (http://datacenter.kidscount.org/databook/2009/Default.aspx). Data are from 2008. Data are not available by race/ethnicity.

Source: Annie E. Casey Foundation's Texas Kids Count. Data are for 2008 and are based on children 0-17 years of age. Data are not available by race/ethnicity.

Source: ACS-Monthly Medicaid enrollment files. Demographic Analysis Unit, Strategic Decision Support, Health and Human Services Commission, Texas, 2009.

Source: ACS-Monthly Medicaid enrollment files. Demographic Analysis Unit, Strategic Decision Support, Health and Human Services Commission, Texas, 2009.

Source: Texas Food Stamp Client Profile, Strategic Decision Support, Health and Human Services Commission, Texas, 2008.

These data are reported through certification data provdied by the WIC program.

Source: Oral Communication with Texas Department of Public Safety. Maggie Walker, Statistician, Uniform Crime Reporting, maggie.walker@txdps.state.tx.us
Data are for 2008.

Source: Texas Education Agency (http://ritter.tea.state.tx.us/research/pdfs/2009_comp_annual.pdf). Data are from 2008 academic year.

Source: Texas Department of Family and Protective Services (http://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2009/2009databook.pdf). Data from 2009.

Narrative:
Texas has the third largest Hispanic population in the 0 to 19 years age group and is one of only four states in which Hispanics account for more than 40% of this age group. By 2015, children of Hispanic origins will account for a greater proportion of the Texas population than children of non-Hispanic origin. This shift in population may place an increased burden on the Texas health care infrastructure. As the data presented for HIS #09B indicate, the proportion of children of Hispanic origin enrolled in Medicaid (52.3%), enrolled in the food stamp program (52.5%), enrolled in WIC (27.8%) exceed the proportions of children not of Hispanic origin enrolled in these programs (36.2%, 36.7%, and 8.7%, respectively).

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	6404953
Living in urban areas	6706281
Living in rural areas	480148
Living in frontier areas	68608
Total - all children 0 through 19	7255037

Notes - 2011
Source: 2009 Population Projections from the Office of the State Demographer.

Source: 2009 Population Projections from the Office of the State Demographer.

Source: 2009 Population Projections from the Office of the State Demographer.

Source: 2009 Population Projections from the Office of the State Demographer.

Narrative:
More than 92% of Texas residents live in urban areas. Texas is home to 6 of the 21 largest cities in the United States. With 7,255,037 children ages 0 to 19 years, Texas has the child population equal to Alabama, Arizona, Alaska, Arkansas, Connecticut, Delaware, and the District of Columbia combined. These data summarize the challenge experienced by Texas having to address a sizable population in urban, rural, and frontier areas.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	24873772.0
Percent Below: 50% of poverty	7.1
100% of poverty	16.9
200% of poverty	38.1

Notes - 2011
Total population for 2009 is a projection provided by the Office of the State Demographer.

B17002. Ratio of income to poverty level in the past 12 months
Universe: Population for whom poverty status is determined
Data Set: 2005-2007 American Community Survey 3-Year Estimates
Survey: American Community Survey

B17002. Ratio of income to poverty level in the past 12 months
Universe: Population for whom poverty status is determined
Data Set: 2005-2007 American Community Survey 3-Year Estimates
Survey: American Community Survey

B17002. Ratio of income to poverty level in the past 12 months
Universe: Population for whom poverty status is determined
Data Set: 2005-2007 American Community Survey 3-Year Estimates
Survey: American Community Survey

Narrative:
Texas has one of the highest rates of poverty of any state in the United States. More than one-third of the Texas population is within 200% of poverty. More than 1.7 million people in Texas are within 50% of poverty. More than 4.2 million people in Texas are within 100% of poverty. More than 9.4 million people in Texas are within 200% of poverty.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	7255037.0
Percent Below: 50% of poverty	9.2
100% of poverty	20.8
200% of poverty	46.0

Notes - 2011
Total population for 2009 is a projection provided by the Office of the State Demographer.

Source: US Census, 2000. American Community Survey was not used as in HSI #11 because the age breakdown is not consistent with the measure.

Source: US Census, 2000. American Community Survey was not used as in HSI #11 because the age breakdown is not consistent with the measure.

Source: US Census, 2000. American Community Survey was not used as in HSI #11 because the age breakdown is not consistent with the measure.

Narrative:
Approximately half of all Texas children live within 200% of poverty, which is about 3.3 million children. This is greater than the entire child population of all but three states (California, Illinois,

and Florida). One-fifth of all Texas children live within 100% of poverty, which is about 1.5 million children. This is greater than the entire child population of 33 states. About ten percent of all Texas children live within 50% of poverty, which is about 700,000 children. This is greater than the entire child population of 16 states.

F. Other Program Activities

FAMILY/CONSUMER PARTICIPATION

CSHCN SP actively engages consumers and families in the decision-making process. Community-based contractors receiving funding through CSHCN SP have significant parent or parent/professional leadership and participate in advisory boards, meetings, and work groups. Family members attend and actively participate in quarterly conference calls for the Medical Home Work Group, and family member representatives from several contractors participate in bi-monthly conference calls for the Transition Team. CSHCN SP provides funding for the Leadership Education in Adolescent Health (LEAH) project at Baylor College of Medicine in Houston which enables 50 family members from throughout the state to attend the annual LEAH transition conference. The program has strong ties with Texas Parent to Parent (TxP2P), the federally funded Family-to-Family Health Care Education and Information Center and collaborates with their efforts to educate parents and caregivers. Staff participate in the TxP2P annual conference as speakers, planners, and exhibitors. Staff work with parents and teens to execute the Teen Transition Expo which is part of the TxP2P annual conference.
Parents of CYSHCN in various geographic locations have become Family Voices representatives and are key advocates for improving access to and coordination of health and other services for CYSHCN. Regional social work staff and the program's community-based service contractors work to facilitate family access to services, promote family networking, increase family involvement in community service system development decisions, and obtain family feedback.

Consumers and family members receiving services through Title V contracted providers participated in the FY11 Five-Year Needs Assessment process through focus groups, community listening sessions, and surveys, resulting in more direct contact and enhanced response than had been historically achieved through less personal methods. Title V staff participate in a large number of statewide councils and workgroups with family member representation or leadership. DSHS regional staff attend and participate in local or regional meetings and events, which emphasize family member involvement.

2-1-1 TEXAS

Through a public/private collaboration of the United Way and other community-based organizations, HHSC administers 2-1-1 Texas, a toll-free, one-stop telephone resource to receive information and referrals for existing health and social services resources throughout Texas. Calls are routed to one of 25 local agencies contracted to answer calls for a certain geographic area where trained resource specialists ascertain the caller‘s need and assist them utilizing a comprehensive database listing of health and social services for the local area. In addition, individuals can call 2-1-1 to begin the eligibility determination process for services such as Medicaid, CHIP, and the Supplemental Nutrition Assistance Program. A searchable database of services is available to the public at https://www.211texas.org/211/search.do. 2-1-1 has also become an important component in Texas' disaster response. During Hurricane Ike and the recent H1N1 flu outbreak, 2-1-1 Texas quickly and efficiently shared emergency response information to assist people affected. In Texas, calls to the 1-800-311-BABY line for information on maternal and child and health are answered by 2-1-1 resource specialists.
In FY09, 2-1-1 Texas handled over 2.4 million calls. Approximately 130,000 of these calls were categorized, according to the taxonomy guidelines, as related to maternal and child health. The top category was for dental care, with more than 14,000 calls.

CHILD FATALITY REVIEW

Title V staff coordinate the work of the State Child Fatality Review Team (SCFRT) Committee, a statutorily-defined multidisciplinary group of professionals who serve to: develop an understanding of the causes and incidences of child deaths in Texas; identify procedures within the agencies represented on the committee to reduce the number of preventable child deaths; and promote public awareness and make recommendations for changes in law, policy, and practice to reduce the number of preventable child deaths. The SCFRT Committee works closely with local child fatality review teams (CFRTs) from across the state. These local CFRTs conduct the actual reviews, provide data on all reviews, and identify local child safety issues. In submitting local data, local teams together create a detailed picture of child death as a public health issue in Texas. The SCFRT Committee reviews the data collected statewide to develop position statements and make recommendations for policy change.

Texas currently has 63 CFR teams that serve 187 counties. There were 506,526 children residing in counties that did not have a CFRT team in 2008 (7.80% of the total population). The remaining 5,988,698 children (92.2%) live in a county that has CFRT coverage.

SAFE SLEEP

The Infant Health Workgroup, comprised of DSHS MCH staff and DFPS staff in the areas of Child Protective Services (CPS) Investigations, Child Care Licensing, and the Division of Prevention and Early Intervention, was recently formed to address activities related to infant health, including safe sleep. A subcommittee of this workgroup developed a community-based training on safe sleep for infants for use by anyone who works with parents -- professionals, paraprofessionals and lay workers. Another subcommittee worked with a social marketing firm to develop a Safe Sleep Environment Assessment training which will be required of all CPS caseworkers.

Title V administers an autopsy reimbursement program mandated by Texas statute that allows counties to claim a fixed reimbursement toward the cost of an autopsy where the cause of death is determined to be Sudden Infant Death Syndrome (SIDS). The program also provides a mechanism to track data related to SIDS deaths to better understand the circumstances surrounding SIDS.

HOME VISITING

HHSC and DSHS leadership have designated the OTV&FH to lead the interagency collaborative process for completing the statewide needs assessment for the Maternal, Infant, and Early Childhood Home Visiting Program as required by the Patient Protection and Affordable Care Act. The home visiting needs assessment interagency workgroup, led by the Title V Director, is currently developing the required home visiting program needs assessment.

G. Technical Assistance

The diverse population, economy, and health needs of Texas continue to evolve in an environment for which resources remain limited, requiring an infrastructure that is effective and efficient. Consideration of the technical assistance needs listed in Form 15 will enhance the state's efforts to meet the needs of the MCH population.

ORAL HEALTH

Technical assistance is requested as Texas continues to search for best practices related to providing and promoting preventive oral health care, training options for providers on oral health screening and care for young children, and enhancing awareness of caregivers about the importance of early preventive oral health care.

Increasing access to dental care was identified in the FY11 Five-Year Needs Assessment Process as one of 10 priority needs. Availability of providers including dentists was one of five most mentioned unmet needs reported in family, provider, and CRCG surveys. In 2010, 46% of the 254 Texas counties had too few dentists. Furthermore, approximately 15 million Texans live in counties with a whole or partial Health Professional Shortage Areas designation as dental shortage areas.

Agency staff have provided support for initiatives such as increasing reimbursement rates for medical and dental providers; providing specialized training to Medicaid dentists on the needs of children under the age of 3; the addition of a new billing code for dental exams for children under the age of 3 to encourage more comprehensive care, including fluoride varnish for children and counseling and education for parents. In addition efforts have been made to provide training and reimbursement for Medicaid pediatricians to perform limited oral evaluations and apply fluoride varnish to children as young as 6 months old within the medical home. Even with these activities, technical assistance is needed to identify mechanisms to further incorporate early preventive oral health care in a variety of health care settings.

SOCIAL DETERMINANTS OF HEALTH/LIFE COURSE PERSPECTIVE

The majority of DSHS services focus on education, technical assistance to providers, and preventive services that impact whole families. Rather than focusing on exclusively providing access to a full range of health care services, DSHS programs provide services that are designed to reach populations. Stakeholder input obtained through the FY11 Five-Year Needs Assessment process often included suggestions to ensure that services are provided in a holistic, coordinated, and culturally competent manner. Therefore, an improved understanding of the role that biological, psychological, behavioral, and social factors plays across the span of a person's life is critical to designing and administering systems for improving health outcomes for women, children, and families in this state. Technical assistance is also needed in assuring that these factors are addressed in a coordinated and comprehensive manner across DSHS program areas.

INTEGRATION OF MENTAL AND BEHAVIORAL HEALTH AND PRIMARY HEALTH CARE

DSHS continues to strengthen the ability of the agency to holistically address the needs of clients impacted by both physical and behavioral health issues. The Family and Community Health Services and Mental Health and Substance Abuse Divisions work with state and local advocates, consumers, families, and other stakeholders to strengthen the availability of a full array of community-based services across Texas. Technical assistance is needed regarding best practices in the areas of policy, training, and service delivery that promote integration of physical, mental, and behavioral health as Title V staff implement activities based on the new state performance measure developed for FY11 related to this effort.

HEALTH CARE REFORM

The Patient Protection and Affordable Care Act (HR 3590) and the Health Care and Education Reconciliation Act of 2010 (HR 4872) were recently enacted into law. Together, the laws make comprehensive reforms that are intended to increase access to health care, provide insurance protections, and improve quality of care. The new laws will significantly affect the operations and budgets of the state and local health and human service agencies. In preparation for the integration of these provisions into existing eligibility determination procedures, client services, and program operations, Title V staff may seek policy input and direction from our federal partners.

COMMUNITY HEALTH WORKER/PARAPROFESSIONAL PROGRAMS

The DSHS Promotora/Community Health Worker (CHW) Program coordinates the training and certification process for becoming a certified promotor(a)/CHW. As a trained peer from within

communities, promotores(as) provide outreach, health education, and referrals to local community members. The CHW program coordinates the Promotor(a)/CHW Training and Certification Advisory Committee that is charged with advising the HHSC Executive Commissioner on rules related to the training and regulation of persons working as promotores(as)/CHWs. As efforts continue to expand the program within the state, examples of existing models and programs in other states, along with available training and other workforce development tools would be helpful to inform the process.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	34184513	23954521	34446314		34437266	
2. Unobligated Balance *(Line2, Form 2)*	6141299	10538576	12894495		8580980	
3. State Funds *(Line3, Form 2)*	46447844	48592084	56129051		54886980	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	250000	500330	250000		250000	
6. Program Income *(Line6, Form 2)*	2527780	1797444	37706		2527780	
7. Subtotal	89551436	85382955	103757566		100683006	
8. Other Federal Funds *(Line10, Form 2)*	575780008	592927876	570310569		605513800	
9. Total *(Line11, Form 2)*	665331444	678310831	674068135		706196806	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	10006532	7088744	8476492		4776187	
b. Infants < 1 year old	89900	79649	99777		57725	
c. Children 1 to 22 years old	17346350	19581839	24268091		20525721	
d. Children with	43087359	42189979	49669910		51907849	

Special Healthcare Needs						
e. Others	12954783	10146566	14100275		16545619	
f. Administration	6066512	6296178	7143021		6869905	
g. SUBTOTAL	89551436	85382955	103757566		100683006	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94644		94644		93713	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	553930301		554091746		581324119	
h. AIDS	0		0		0	
i. CDC	7467337		8526836		7418165	
j. Education	0		0		0	
k. Other						
FamPlanning Title X	0		0		15976467	
NHSCPC/MaleInvolve	0		0		701336	
Fam Planning Title X	0		6896007		0	
NHSCPC/Male Involvem	0		701336		0	
Family Planning(T-X)	13372014		0		0	
NHSCPC/MaleInvolvem	915712		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	60389544	61970312	79083028		73074976	
II. Enabling Services	7080578	4983751	6339478		5876806	
III. Population-Based Services	12214400	11414366	12076131		13459743	
IV. Infrastructure Building Services	9866914	7014526	6258929		8271481	
V. Federal-State Title V Block Grant Partnership Total	89551436	85382955	103757566		100683006	

A. Expenditures

Please note that Attachment V. A. includes the complete set of Forms 2, 3, 4, and 5 as prepared by the DSHS Grant Coordination and Funds Management Branch to provide a complete updated set of budget and expenditure data for FY08 and FY09 as of 7/12/10. Field Notes have also been added to update the individual cells of the tables where needed. The Budgeted amounts for FY11 are estimated since the federal award may change in FY11 and FY10 expenditures are not

final.

Forms 3, 4, and 5 show variations in expenditure amounts from previous years, which are best explained by changes in available prenatal care benefits through CHIP and the impact of changes in CHIP and Medicaid eligibility. From December 2008 to December 2009, the numbers of Medicaid eligible children under age 19 grew 13% to 2,458,117. During the same period, Texas saw an 8.5% increase in monthly enrollment in the Children's Health Insurance Program (CHIP) with a steady enrollment in the state's CHIP Perinatal program that began in 2007. While these changes are positive in providing access to needed care, Title V has continued to maintain infrastructure necessary to provide prenatal care and well-child and dental care through existing contracts, primarily acting as a transitional means of obtaining care while completing the eligibility and enrollment process for CHIP or Medicaid.

Form 3

From FY06 to FY09, expenditures decreased from $87 million to $85 million even as the federal award was slightly increased in the last year. In addition to the impact of a reduction in direct services sought from Title V, there was a change in the calculation of the indirect rate applied to funding that had a substantial impact increasing available funds. As noted in the last application, the result of retrospectively applying the revised formula to client services contracts from FY07 forward resulted in a net increase in the carryforward amount of approximately $1 million each year. While expenditures in state funds increased from $45.8 to $48.5 million from FY06 to FY09, the growth in carryforward funds continues. Mid-year reviews in direct services contracts have been expanded to identify potential opportunities to invest funds in agency collaborative population-based and infrastructure building projects in FY09, FY10, and FY11.

Form 4

Data from FY06 thru FY09 indicate that Title V expenditures for the CSHCN population have increased from $35 to $42 million during that time period. The significant decrease in the expenditures for pregnant women and infants first seen in the FY10 Application continues with the reduction in expenditures from almost $16 million in FY06 to just over $7 million in FY09. As previously noted, the change is tied to the increased availability of alternative sources of direct health care services as noted above. In FY09, an observed increase in expenditures for children 1-22 may be linked to the increased number of children without health insurance as noted in National Performance Measure 13.

Form 5

Within each year, direct services increased in FY08 and FY09 primarily from the increase in CSHCN expenditures; however, there have been slight adjustments in the other three categories of services. FY09 expenditures in Population-Based and Infrastructure Building Services increased as a result of investment in time limited projects focused on utilizing the unobligated funding from the previous period.
An attachment is included in this section.

B. Budget

Maintenance of Effort and Continuation Funding

Texas will continue to provide the maintenance of effort (MOE) amount of $40,208,728 as required. An additional $6 million in state funds has been budgeted, in addition to the $8.5 million carried forward from the FY10 award. Texas continues to exceed the state match rate of $3 state dollars for every $4 federal Title V dollars and provides funding for service categories funded under Title V prior to 1981, including: 1) children with special health care needs services; 2) case management for SSI-eligible children; 3) genetics services; 4) SIDS prevention activities; and 5)

family planning and teen pregnancy prevention services.

30% - 30% Federal Requirement
The Title V program makes good faith efforts to comply with allocating and spending at least 30% of the federal allotment for preventive and primary services for children and at least 30% for specialized services for children with special health care. To achieve the 30% -30% requirement, the Office of Title V and Family Health requires all MCH Title V-funded contractors to provide child health services in the amount of at least 30% of the contracted amount. The Title V program funding supports accountants within the DSHS Budget Office whose primary responsibilities are to set-up proper accounting and financial practices in managing the Title V budget in general, and particularly, to establish internal controls to monitor expenditures of federal funds. The Budget Office's Grants Coordination and Funds Management Unit prepares financial reports on compliance with the 30% - 30% requirement on a monthly basis. The Family and Community Health Services Division and Title V program leadership review reports, provide feedback, and adjust service delivery as needed to maintain the required spending proportions.

For FY11, Form 2 shows that $10,331,180 (or 30% of the estimated federal award) has been budgeted for children and adolescents and an additional $10,331,180 for children with special care needs. The same vigorous monitoring process described above is in place to comply with the 10% cap on administrative expenditures which are budgeted at 3,443,727 in FY11.

Other Sources of Funding for Women and Children

Texas receives other federal, state, and private grants related to women and children. These grants include, but are not limited to: 1) MCHB - State Systems Development Initiative; 2) MCHB - Abstinence Education; 3) MCHB - State Early Childhood Comprehensive Systems; 4) Centers for Disease Control and Prevention (CDC) - Breast and Cervical Cancer Early Detection Program; 5) Support State Oral Disease Prevention Program; 6) Texas Cancer Council - regional school health specialists; 7) Title X State Coordinated Family Planning Project; 8) CDC Pregnancy Risk Assessment Monitoring System; 9) WIC (Farmers Market, Electronic Benefit Transfer, Breastfeeding Peer Counseling); 10) Chronic Disease Prevention and Health promotion- Obesity Component; 11) HRSA Cooperative Agreement for Primary Care Services & Manpower Placement; and 12) CDC - Evidence-Based Laboratory Medicine: Quality/Performance Measure Evaluation; 13) CDC - Texas Early Hearing & Detection & Intervention Tracking, Surveillance & Integration; and 14) ARRA funding and potential funding that may be available through the Affordable Health Care Act.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.